

IDAHO CODE

TITLE 41

INSURANCE

Current through 2020 Regular Session

MICHIE

This eBook belongs to

The People of Idaho

This Ebook Was Purchased By Public Resource

On Their Behalf

IDAHO CODE

CONTAINING THE

GENERAL LAWS OF IDAHO
ANNOTATED

ORIGINALLY PUBLISHED BY AUTHORITY OF
LAWS 1947, CHAPTER 224

REPUBLISHED BY AUTHORITY OF
LAWS 1949, CHAPTER 167 AS AMENDED

Compiled Under the Supervision of the
Idaho Code Commission

R. DANIEL BOWEN
ANDREW P. DOMAN JILL S. HOLINKA
COMMISSIONERS

TITLE 41

MICHIE

LexisNexis and the Knowledge Burst logo are registered trademarks, and MICHIE is a trademark of Reed Elsevier Properties, Inc., used under license. Matthew Bender is a registered trademark of Matthew Bender Properties, Inc.

© 2020 State of Idaho
All rights reserved.

ISBN 978-1-5221-5466-2 (print)

ISBN 978-0-327-19265-7 (eBook)

Terms of Use

Your use of this electronic publication (“eBook”) from LexisNexis, a division of RELX Inc., a Massachusetts corporation, or its affiliates, is subject to the following terms and conditions. This eBook is for your personal use only. All access to and use of this eBook is subject to U.S. and international copyright law. All intellectual property rights are reserved to the copyright holder. Redistribution or duplication of this eBook to any other electronic media or a third party is strictly prohibited. Under no circumstances may you redistribute this eBook commercially or post this eBook on an intranet, internet or SharePoint site. Finally, use of this eBook is further subject to the terms and conditions of use which were accepted at the time you completed your purchase of this eBook from the point of purchase.

PUBLISHER'S NOTE

This publication contains annotations taken from decisions of the Idaho Supreme Court and the Court of Appeals and the appropriate federal courts. These cases will be printed in the following reports: Idaho Reports

Pacific Reporter

Federal Supplement

Federal Reporter

United States Supreme Court Reports, Lawyers' Edition Following is an explanation of the abbreviations of the Court Rules used throughout the Idaho Code.

Idaho R. Civ. P.	Idaho Rules of Civil Procedure
Idaho Evidence Rule	Idaho Rules of Evidence
Idaho R. Crim. P.	Idaho Criminal Rules
Idaho Misdemeanor Crim. Rule	Misdemeanor Criminal Rules
I.I.R.	Idaho Infraction Rules
I.J.R.	Idaho Juvenile Rules
I.C.A.R.	Idaho Court Administrative Rules
Idaho App. R.	Idaho Appellate Rules

If you have any questions or suggestions concerning the Idaho Code, please write or call toll free 1-800-833-9844, fax toll free at 1-800-643-1280, or email us at customer.support@bender.com.

Visit our website at <http://www.lexisnexis.com> for an online bookstore, technical support, customer service, and other company information.

LexisNexis

701 East Water Street Charlottesville, VA 22902

USER'S GUIDE

To assist the legal profession and the layperson in obtaining the maximum benefit from the Idaho Code, a User's Guide has been included in the first volume of this set.

ADJOURNMENT DATES OF SESSIONS OF LEGISLATURE

Article 3, § 22 of the Idaho State Constitution provides: “No act shall take effect until sixty days from the end of the session at which the same shall have been passed, except in case of emergency, which emergency shall be declared in the preamble or in the body of the law.”

Section 67-510 Idaho Code provides: “No act shall take effect until July 1 of the year of the regular session or sixty (60) days from the end of the session at which the same shall have been passed, whichever date occurs last, except in case of emergency, which emergency shall be declared in the preamble or body of the law.

Every joint resolution, unless a different time is prescribed therein, takes effect from its passage.”

This table is given in order that the effective date of acts, not carrying an emergency or which do not specify an effective date, may be determined with a minimum of delay.

Year	Adjournment Date
1921	March 5, 1921
1923	March 9, 1923
1925	March 5, 1925
1927	March 3, 1927
1929	March 7, 1929
1931	March 5, 1931
1931 (E.S.)	March 13, 1931
1933	March 1, 1933
1933 (E.S.)	June 22, 1933
1935	March 8, 1935
1935 (1st E.S.)	March 20, 1935
1935 (2nd E.S.)	July 10, 1935
1935 (3rd E.S.)	July 31, 1936

1937	March 6, 1937
1937 (E.S.)	November 30, 1938
1939	March 2, 1939
1941	March 8, 1941
1943	February 28, 1943
1944 (1st E.S.)	March 1, 1944
1944 (2nd E.S.)	March 4, 1944
1945	March 9, 1945
1946 (1st E.S.)	March 7, 1946
1947	March 7, 1947
1949	March 4, 1949
1950 (E.S.)	February 25, 1950
1951	March 12, 1951
1952 (E.S.)	January 16, 1952
1953	March 6, 1953
1955	March 5, 1955
1957	March 16, 1957
1959	March 9, 1959
1961	March 2, 1961
1961 (1st E.S.)	August 4, 1961
1963	March 19, 1963
1964 (E.S.)	August 1, 1964
1965	March 18, 1965
1965 (1st E.S.)	March 25, 1965
1966 (2nd E.S.)	March 5, 1966
1966 (3rd E.S.)	March 17, 1966
1967	March 31, 1967
1967 (1st E.S.)	June 23, 1967
1968 (2nd E.S.)	February 9, 1968
1969	March 27, 1969
1970	March 7, 1970
1971	March 19, 1971

1971 (E.S.)	April 8, 1971
1972	March 25, 1972
1973	March 13, 1973
1974	March 30, 1974
1975	March 22, 1975
1976	March 19, 1976
1977	March 21, 1977
1978	March 18, 1978
1979	March 26, 1979
1980	March 31, 1980
1981	March 27, 1981
1981 (E.S.)	July 21, 1981
1982	March 24, 1982
1983	April 14, 1983
1983 (E.S.)	May 11, 1983
1984	March 31, 1984
1985	March 13, 1985
1986	March 28, 1986
1987	April 1, 1987
1988	March 31, 1988
1989	March 29, 1989
1990	March 30, 1990
1991	March 30, 1991
1992	April 3, 1992
1992 (E.S.)	July 28, 1992
1993	March 27, 1993
1994	April 1, 1994
1995	March 17, 1995
1996	March 15, 1996
1997	March 19, 1997
1998	March 23, 1998
1999	March 19, 1999

2000	April 5, 2000
2001	March 30, 2001
2002	March 15, 2002
2003	May 3, 2003
2004	March 20, 2004
2005	April 6, 2005
2006	April 11, 2006
2006 (E.S)	August 25, 2006
2007	March 30, 2007
2008	April 2, 2008
2009	May 8, 2009
2010	March 29, 2010
2011	April 7, 2011
2012	March 29, 2012
2013	April 4, 2013
2014	March 20, 2014
2015	April 11, 2015
2015 (E.S.)	May 18, 2015
2016	March 25, 2016
2017	March 29, 2017
2018	March 28, 2018
2019	April 11, 2019
2020	March 20, 2020

Idaho Code Title 41

**Title 41
INSURANCE****Chapter**

- Chapter 1. Scope of Insurance Code — General Provisions, §§ 41-101 — 41-121.
- Chapter 2. The Department of Insurance, §§ 41-201 — 41-298.
- Chapter 3. Authorization of Insurers and General Requirements, §§ 41-301 — 41-349.
- Chapter 4. Fees and Taxes, §§ 41-401 — 41-406.
- Chapter 5. Kinds of Insurance — Limits of Risk — Reinsurance, §§ 41-501 — 41-516.
- Chapter 6. Assets and Liabilities, §§ 41-601 — 41-616.
- Chapter 7. Investments, §§ 41-701 — 41-736.
- Chapter 8. Administration of Deposits, §§ 41-801 — 41-813.
- Chapter 9. Insurance Administrators, §§ 41-901 — 41-917.
- Chapter 10. Producer Licensing, §§ 41-1001 — 41-1097.
- Chapter 11. Adjusters, §§ 41-1101 — 41-1108.
- Chapter 12. Unauthorized Insurers and Surplus Lines, §§ 41-1201 — 41-1237.
- Chapter 13. Trade Practices and Frauds, §§ 41-1301 — 41-1338.
- Chapter 14. Property Insurance Rates, §§ 41-1401 — 41-1441.
- Chapter 15. Managing General Agents Act, §§ 41-1501 — 41-1507.
- Chapter 16. Worker's Compensation Rates, §§ 41-1601 — 41-1626.
- Chapter 17. Business Transacted with Broker Controlled Insurer, §§ 41-1701 — 41-1706.
- Chapter 18. The Insurance Contract, §§ 41-1801 — 41-1852.
- Chapter 19. Life Insurance Policies and Annuity Contracts, §§ 41-1901 — 41-1965.
- Chapter 20. Group Life Insurance, §§ 41-2001 — 41-2026.
- Chapter 21. Disability Insurance Policies, §§ 41-2101 — 41-2146.
- Chapter 22. Group and Blanket Disability Insurance, §§ 41-2201 — 41-2223.
- Chapter 23. Credit Life and Credit Disability Insurance, §§ 41-2301 — 41-2316.
- Chapter 24. Property Insurance Contracts, § 41-2401.
- Chapter 25. Casualty Insurance Contracts, §§ 41-2501 — 41-2521.
- Chapter 26. Surety Insurance Contracts, §§ 41-2601 — 41-2613.
- Chapter 26A. Mortgage Guaranty Insurance, §§ 41-2650 — 41-2656.
- Chapter 27. Title Insurance, §§ 41-2701 — 41-2714.
- Chapter 28. Organization and Corporate Procedures of Stock and Mutual Insurers, §§ 41-2801 — 41-2873.
- Chapter 29. Reciprocal Insurers, §§ 41-2901 — 41-2930.
- Chapter 30. Idaho Unclaimed Life Insurance Benefits Act, §§ 41-3001 — 41-3003.
- Chapter 31. County Mutual Insurers, §§ 41-3101 — 41-3119.
- Chapter 32. Fraternal Benefit Societies, §§ 41-3201 — 41-3240.
- Chapter 33. Insurers Supervision, Rehabilitation and Liquidation, §§ 41-3301 — 41-3360.
- Chapter 34. Hospital and Professional Service Corporations, §§ 41-3401 — 41-3444.
- Chapter 35. Insurance of Public Property and Risks, §§ 41-3501 — 41-3504.
- Chapter 36. Insurance Guaranty Association, §§ 41-3601 — 41-3621.
- Chapter 37. Idaho Hospital Liability Trust Act. [Repealed.]
- Chapter 38. Acquisitions of Control and Insurance Holding Company Systems, §§ 41-3801 — 41-3825.
- Chapter 39. Managed Care Reform, §§ 41-3901 — 41-3940.
- Chapter 40. Self-Funded Health Care Plans, §§ 41-4001 — 41-4026.
- Chapter 41. Joint Public Agency Self-Funded Health Care Plans, §§ 41-4101 — 41-4125.
- Chapter 42. Individual Accident and Health Insurance Policies, §§ 41-4201 — 41-4207.
- Chapter 43. Idaho Life and Health Insurance Guaranty Association Act, §§ 41-4301 — 41-4320.
- Chapter 44. Medicare Supplement Insurance Minimum Standards, §§ 41-4401 — 41-4411.
- Chapter 45. Motor Clubs. [Repealed.]
- Chapter 46. Long-Term Care Insurance Act, §§ 41-4601 — 41-4611.
- Chapter 47. Small Employer Health Insurance Availability Act, §§ 41-4701 — 41-4718.
- Chapter 48. Risk Retention Groups, §§ 41-4801 — 41-4816.
- Chapter 49. Petroleum Clean Water Trust Fund Act, §§ 41-4901 — 41-4948.
- Chapter 50. Underground Storage Tank Upgrade Assistance Program. [Repealed.]
- Chapter 51. Reinsurance Intermediary Act, §§ 41-5101 — 41-5111.
- Chapter 52. Individual Health Insurance Availability Act, §§ 41-5201 — 41-5214.
- Chapter 53. Medical Care Savings Account Act. [Repealed.]
- Chapter 54. Risk-Based Capital (RBC) for Insurers Act, §§ 41-5401 — 41-5413.
- Chapter 55. Idaho Individual High Risk Reinsurance Pool, §§ 41-5501 — 41-5511.
- Chapter 56. Prompt Payment of Claims, §§ 41-5601 — 41-5606.
- Chapter 57. Interstate Insurance Product Regulation Compact, §§ 41-5701, 41-5702.
- Chapter 58. Public Adjuster Licensing Act, §§ 41-5801 — 41-5821.

Chapter 59. Idaho Health Carrier External Review Act, §§ 41-5901 — 41-5917.

Chapter 60. Immunization Assessments, §§ 41-6001 — 41-6008.

Chapter 61. Idaho Health Insurance Exchange Act, §§ 41-6101 — 41-6109.

Chapter 62. Idaho Motor Vehicle Service Contract Act, §§ 41-6201 — 41-6211.

Chapter 63. Own Risk and Solvency Assessment, §§ 41-6301 — 41-6308.

Chapter 64. Corporate Governance Annual Disclosure, §§ 41-6401 — 41-6406.

Chapter 65. Coverage for Participants in Clinical Trials, §§ 41-6501 — 41-6507.

Chapter 1

SCOPE OF INSURANCE CODE — GENERAL PROVISIONS

Sec.

41-101. Short title.

41-102. “Insurance” defined.

41-103. “Insurer” defined.

41-104. “Person” defined.

41-105. “Director,” “department” defined.

41-106. “Domestic,” “foreign,” “alien” insurer defined.

41-107. “State” defined.

41-108. “Domicile” defined.

41-109. “Principal office” defined.

41-110. “Authorized,” “unauthorized” insurer defined.

41-111. “Certificate of authority,” “license” defined.

41-112. “Transacting insurance” defined.

41-113. Compliance required — Public interest.

41-114. Application of code as to particular types of insurers.

41-114A. Service contracts.

41-114B. Legal service expense plans.

41-115. Particular provisions prevail.

41-116. Captions not to affect meaning.

41-117. General penalty.

41-117A. Penalty for transacting insurance without proper licensing.

41-118. “Chapter” defined.

41-119. Applicability of code under unrepealed laws.

41-120. Charitable gift annuities.

41-121. Exemption of health care sharing ministries from the insurance code.

§ 41-101. Short title. — This act constitutes the Idaho insurance code.

History.

1961, ch. 330, § 1, p. 645.

STATUTORY NOTES

Compiler's Notes.

The words “this act” refer to S.L. 1961, ch. 330, which is compiled throughout chapters 1 to 8, 11 to 14, 16, 18 to 26, 27 to 29, 31, 34, and 35 of this title.

CASE NOTES

Cited *Smith v. Great Basin Grain Co.*, 98 Idaho 266, 561 P.2d 1299 (1977).

§ 41-102. “Insurance” defined. — “Insurance” is a contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies.

History.

1961, ch. 330, § 2, p. 645.

CASE NOTES

Applicability.

Preneed funeral service.

Applicability.

A company was not an insurer where there was no evidence in the record that the company had guaranteed or assured payment of members’ claims; thus, the conclusion that the company’s membership contract was an insurance contract because the company assumed some risk of paying its members’ claims was clearly erroneous. *Altrua Healthshare, Inc. v. Deal*, 154 Idaho 390, 299 P.3d 197 (2013).

Preneed Funeral Service.

Although preneed funeral service contracts provided that the full amount of contract would be paid at time of death, if a certain portion of the premium had been paid within 31 days, and that, in event of death of minor children, interment space would be free for such child, such contracts, providing for the purchase of services and merchandise, with delivery postponed until after death, were not insurance contracts which were illegal and void because the company was not qualified as an insurance company. *Messerli v. Monarch Memory Gardens, Inc.*, 88 Idaho 88, 397 P.2d 34 (1964) (ruling concurred in by majority of judges).

Cited *County of Kootenai v. Western Cas. & Sur. Co.*, 113 Idaho 908, 750 P.2d 87 (1988).

Idaho Code § 41-103

§ 41-103. “Insurer” defined. — “Insurer” includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

History.

1961, ch. 330, § 3, p. 645.

CASE NOTES

Cited Smith v. Great Basin Grain Co., 98 Idaho 266, 561 P.2d 1299 (1977); Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987); State v. Gardiner, 127 Idaho 156, 898 P.2d 615 (Ct. App. 1995).

§ 41-104. “Person” defined. — “Person” includes any individual, insurer, company, association, organization, Lloyd’s insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity.

History.

1961, ch. 330, § 4, p. 645.

§ 41-105. “Director,” “department” defined. — (1) “Director” means the director of the department of insurance of this state.

(2) “Department” means the department of insurance of this state.

History.

1961, ch. 330, § 5, p. 645.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Department of insurance, § 41-201 et seq.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-106. “Domestic,” “foreign,” “alien” insurer defined. — (1) A “domestic” insurer is one formed under the laws of this state or an insurer which has transferred its domicile pursuant to [section 41-342, Idaho Code](#), to this state.

(2) A “foreign” insurer is one formed under the laws of a jurisdiction other than this state.

(3) An “alien” insurer is one formed under the laws of any country other than the United States of America, its states, districts, territories, and commonwealths.

(4) Except where distinguished by context, “foreign” insurers includes also “alien” insurers.

History.

1961, ch. 330, § 6, p. 645; am. 1987, ch. 302, § 4, p. 640.

§ 41-107. “State” defined. — When used in context signifying a jurisdiction other than the state of Idaho, “state” means any state, district, territory, commonwealth, or possession of the United States of America, and the Panama Canal Zone.

History.

1961, ch. 330, § 7, p. 645.

§ 41-108. “Domicile” defined. — The “domicile” of an insurer means:

(1) As to Canadian insurers, Canada and the province in which the insurer’s head office is located.

(2) As to other alien insurers authorized to transact insurance in one or more states, as provided in section 41-340[, Idaho Code] (retaliatory provision).

(3) As to alien insurers not authorized to transact insurance in one or more states, the country under the laws of which the insurer was formed.

(4) As to all other insurers, the state under the laws of which the insurer was formed or the state to which the insurer has transferred its domicile.

History.

1961, ch. 330, § 8, p. 645; am. 1987, ch. 302, § 5, p. 640.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertion in subsection (2) was added by the compiler to conform to the statutory citation style.

§ 41-109. “Principal office” defined. — “Principal office” means:

(1) As to Canadian insurers, the office in Canada from which the general affairs of the insurer are directed or managed;

(2) As to other alien insurers authorized to transact insurance in one or more states, the office in United States from which the general affairs of the insurer in the United States are directed or managed;

(3) As to all other insurers, the office from which the general affairs of the insurer are directed or managed.

History.

1961, ch. 330, § 9, p. 645.

§ 41-110. “Authorized,” “unauthorized” insurer defined. — (1) An “authorized” insurer is one duly authorized by a subsisting certificate of authority issued by the director to transact insurance in this state.

(2) An “unauthorized” insurer is one not so authorized.

History.

1961, ch. 330, § 10, p. 645.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-111. “Certificate of authority,” “license” defined. — (1) A “certificate of authority” is one issued by the director evidencing the authority of an insurer to transact insurance in this state.

(2) A “license” is authority granted by the director pursuant to this code authorizing the licensee to engage in a business or operation of insurance in this state other than as an insurer, and the certificate by which such authority is evidenced.

History.

1961, ch. 330, § 11, p. 645.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-112. “Transacting insurance” defined. — “Transacting insurance” includes any of the following:

- (1) Solicitation and inducement.
- (2) Preliminary negotiations.
- (3) Effectuation of a contract of insurance.
- (4) Transaction of matters subsequent to effectuation of a contract of insurance and arising out of it.
- (5) Mailing or otherwise delivering any written solicitation to any person in this state by an insurer or any person acting on behalf of the insurer for fee or compensation.

History.

1961, ch. 330, § 12, p. 645; am. 1971, ch. 328, § 1, p. 1293.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 1971, ch. 328 declared an emergency. Approved March 30, 1971.

CASE NOTES

Transacting Insurance.

In determining whether an employment services provider to small businesses transacted insurance under this section, the Idaho supreme court, reviewing a decision of the director of the Idaho department of insurance de novo, was not required to determine whether the provider was a professional employer under Idaho law or whether it sold insurance pursuant to § 44-2403(5)(d). Rather, the provider transacted insurance and, thus, was required to have a certificate of authority to do so; the provider’s agreements with its clients, wherein it received compensation from its clients and from the clients’ employees and, in exchange, it was required to

pay benefits, constituted contracts of insurance. *Emplrs Res. Mgmt. Co. v. Dep't of Ins.*, 143 Idaho 179, 141 P.3d 1048 (2006), overruled on other grounds, *Verska v. St. Alphonsus Med. Ctr.*, 151 Idaho 889, 265 P.3d 502 (2011).

§ 41-113. Compliance required — Public interest. — (1) No person shall transact a business of insurance in Idaho, or relative to a subject of insurance resident, located or to be performed in Idaho, without complying with the applicable provisions of this code.

(2) The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, and their representatives, and all concerned in insurance transactions, rests the duty of preserving the integrity of insurance.

History.

1961, ch. 330, § 13, p. 645.

CASE NOTES

Negligence Per Se.

Where insured failed to show that his claims were covered under his policy and the district court found that insured had not shown that the insurer engaged in any deceptive conduct or acted without good faith in handling or denying the insured's claims, the court properly dismissed the insured's negligence per se claim. *Rizzo v. State Farm Ins. Co.*, 155 Idaho 75, 305 P.3d 519 (2013).

§ 41-114. Application of code as to particular types of insurers. — No provision of chapter 1, title 41, Idaho Code, shall apply with respect to:

(1) County mutual insurers (as identified in chapter 31, title 41, Idaho Code), except as stated in chapter 31, title 41, Idaho Code (County Mutual Insurers).

(2) Fraternal benefit societies (as identified in chapter 32, title 41, Idaho Code), except as stated in chapter 32, title 41, Idaho Code (Fraternal Benefit Societies).

(3) Hospital and medical professional service corporations (as identified in chapter 34, title 41, Idaho Code), except as stated in chapter 34, title 41, Idaho Code (Hospital and Professional Service Corporations).

(4) Religious corporations or societies which are exempt from taxation pursuant to [section 501\(c\)\(3\) of the Internal Revenue Code](#), as amended, and that provide only first-party property or casualty coverages exclusively to their members.

(5) Any organization described by [section 501\(c\)\(3\) of the Internal Revenue Code](#), as amended, but only with respect to the organization's issuance of charitable gift annuities in accordance with the terms of [section 41-120, Idaho Code](#).

History.

1961, ch. 330, § 14, p. 645; am. 1977, ch. 204, § 1, p. 555; am. 1984, ch. 253, § 1, p. 604; am. 1986, ch. 119, § 1, p. 313; am. 1996, ch. 409, § 1, p. 1354; am. 2020, ch. 115, § 2, p. 365.

STATUTORY NOTES

Amendments.

The 2020 amendment, by ch. 115, deleted former subsections (1) and (5), which read, “(1) Domestic mutual benefit insurers (as identified in chapter 30), except as stated in chapter 30 (Mutual Benefit Associations)” and “(5) Hospital trusts (as identified in chapter 37), except as stated in said chapter

37 (Idaho Hospital Liability Trust Act)” and renumbered the remaining subsections accordingly.

Federal References.

Section 501(c)(3) of the Internal Revenue Code, referred to in subsections (4) and (5), is compiled as 26 U.S.C.S. § 501(c)(3).

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Cited Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

§ 41-114A. Service contracts. — (1) The term “service contract,” as used in this section, means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement or maintenance of property or to reimburse, in whole or in part, the owner of such property for the repair, replacement or maintenance of property if an operational or structural failure is due to a defect in materials or manufacturing or to normal wear and tear. A service contract may contain a provision for incidental payment under such contract where service, repair or replacement is not feasible or economical. Service contracts, other than motor vehicle service contracts subject to the provisions of the Idaho motor vehicle service contract act, chapter 62, title 41, Idaho Code, may provide for the repair, replacement or maintenance of property for damage resulting from power surges and accidental damage from handling.

(2) The marketing, sale, offering for sale, issuance, making, proposing to make, and administration of a service contract is exempt from the provisions of title 41, Idaho Code.

(3) Service contracts shall be subject to the provisions of the Idaho consumer protection act, chapter 6, title 48, Idaho Code.

History.

I.C., § 41-114A, as added by 2000, ch. 249, § 1, p. 702; am. 2008, ch. 137, § 1, p. 396; am. 2018, ch. 116, § 3, p. 241.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 137, added the last sentence in subsection (1).

The 2018 amendment, by ch. 116, substituted “chapter 62, title 41, Idaho Code” for “chapter 28, title 49, Idaho Code” near the middle of the last sentence in subsection (1).

Compiler’s Notes.

Section 2 of S.L. 2000, ch. 26 reads: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval, and shall be applicable to all proceedings pending before the Department of Insurance or the courts of this state on the effective date of this act.” Approved April 12, 2000.

§ 41-114B. Legal service expense plans. — (1) The term “legal service expense plan,” as used in this section, means a contract or agreement for a stated consideration between a plan administrator and a member or group of members, whereby the member pays the administrator, in advance or by installments, for the receipt of professional legal services, advice or representation. Such services in Idaho shall be provided by attorneys at law licensed in Idaho. The attorneys shall be prepaid under a contract or agreement with the administrator to provide specified legal services for the express benefit of the plan member and shall agree to render services to the member when required.

(2) The marketing, sale, contracting, issuance of a contract, plan administration and delivery of services under a legal service expense plan are exempt from all other provisions of title 41, Idaho Code. In addition, such plans shall not be characterized as “insurance” when marketed in Idaho.

(3) Legal service expense plans, but not law firm retainer agreements, shall be subject to the provisions of the Idaho consumer protection act, chapter 6, title 48, Idaho Code, and attorneys providing service shall be subject to the provisions relating to the regulation of the practice of law under title 3, Idaho Code.

History.

I.C., § 41-114B, as added by 2001, ch. 127, § 1, p. 449.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2001, ch. 127 declared an emergency. Approved March 23, 2001.

§ 41-115. Particular provisions prevail. — Provisions of this code relative to a particular kind of insurance or a particular type of insurer or to a particular matter shall prevail over provisions relating to insurance in general or insurers in general or to such matter in general.

History.

1961, ch. 330, § 15, p. 645.

CASE NOTES

Cited Maxwell v. Cumberland Life Ins. Co., 113 Idaho 808, 748 P.2d 392 (1987); Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

§ 41-116. Captions not to affect meaning. — The scope and meaning of any provision of this code shall not be limited or otherwise affected by the caption or heading of any chapter, section or provision.

History.

1961, ch. 330, § 16, p. 645.

§ 41-117. General penalty. — Each violation of this code for which a greater penalty is not provided by another provision of this code or by other applicable laws of this state, shall in addition to any applicable prescribed denial, suspension, or revocation of certificate of authority or license be punishable by an administrative penalty of not more than one thousand dollars (\$1,000) for any individual or natural person and not more than five thousand dollars (\$5,000) for any other person, imposed by the director, and upon conviction by a fine of not more than one thousand dollars (\$1,000) or by imprisonment in the county jail for a period not to exceed six (6) months, or by both such fine and imprisonment in the discretion of the court. Each instance of violation may be considered a separate offense.

History.

1961, ch. 330, § 17, p. 645; am. 1999, ch. 96, § 1, p. 298.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

§ 41-117A. Penalty for transacting insurance without proper licensing. — The director may impose an administrative penalty not to exceed fifteen thousand dollars (\$15,000), for deposit in the general account of the state of Idaho, upon any person who transacts insurance of any kind or character or transmits for a person, other than himself, an application for a policy of insurance without proper licensing, or after such licensing shall have been suspended or revoked.

History.

I.C., § 41-117A, as added by 1988, ch. 169, § 1, p. 299.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

General fund, § 67-1205.

CASE NOTES

Limitation on Penalty.

Employment service provider that offered a variety of services to small businesses, including insurance services, was a multiple employer welfare arrangement, as defined by 29 U.S.C.S. § 1002(40), because it offered health benefits to two or more employers; thus, it violated the Idaho Code by transacting the business of insurance without a certificate of authority. However, the total penalty was limited to \$15,000, rather than allowing a penalty for each violation. *Emplrs Res. Mgmt. Co. v. Dep't of Ins.*, 143 Idaho 179, 141 P.3d 1048 (2006), overruled on other grounds, *Verska v. St. Alphonsus Med. Ctr.*, 151 Idaho 889, 265 P.3d 502 (2011).

§ 41-118. “Chapter” defined. — As used in this code and except as otherwise required by context, “chapter” means a particular numbered chapter of this code as indicated by context.

History.

1961, ch. 330, § 804, p. 645.

§ 41-119. Applicability of code under unrepealed laws. — Any laws of Idaho, other than this code, remaining in force after the effective date of this code which refer to certain provisions of law repealed under section 809 of this act, shall be deemed to refer to those provisions of this code which are in substance the same or substantially the same as such repealed provisions.

History.

1961, ch. 330, § 805, p. 645.

STATUTORY NOTES

Compiler's Notes.

The phrase “the effective date of this code” refers to the effective date of S.L. 1961, Chapter 330, which was January 1, 1962.

“Section 809 of this act” near the middle of this section refers to § 809 of S.L. 1961, ch. 330. Said section repealed almost the entire title 41 of the Idaho Code as published in 1947; the remainder of chapter 330 of S.L. 1961 is compiled as most of present title 41.

§ 41-120. Charitable gift annuities. — (1) As used in this section:

(a) “Charitable gift annuity” means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one (1) or two (2) lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes.

(b) “Charitable organization” means an entity described by sections 501(c)(3) or 170(c) of the internal revenue code of 1986 (26 U.S.C. 501(c)(3) or 170(c)).

(c) “Qualified charitable gift annuity” means a charitable gift annuity described in sections 501(m)(5) and 514(c)(5) of the internal revenue code of 1986 (26 U.S.C. 501(m)(5) and (514(c)(5))), that is issued by a charitable organization that, on the date of the annuity agreement:

(i) Has a minimum of one hundred thousand dollars (\$100,000) (after being adjusted annually by the department for inflation, beginning on July 1, 1997, by reference to the city index of the consumer price index or some equivalent measure) in unrestricted cash, cash equivalents, or publicly traded securities, exclusive of the assets funding the annuity agreement; and

(ii) Has been in continuous operation for at least three (3) years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least three (3) years.

(2) It is hereby declared that the issuance of a qualified charitable gift annuity does not constitute engaging in the business of insurance in this state. A charitable gift annuity issued before July 1, 1996, is a qualified charitable gift annuity for purposes of this section and the issuance of such a charitable gift annuity does not constitute engaging in the business of insurance in this state.

(3) When entering into an agreement for a qualified charitable gift annuity, the charitable organization shall disclose in writing to the donor, in the annuity agreement, that a qualified charitable gift annuity is not

insurance under the laws of this state and is not subject to regulation by the department of insurance or protected by a guaranty association affiliated with the department. The notice provisions of this subsection must be written in a separate paragraph in the annuity agreement in a print size no smaller than that employed in the annuity agreement generally.

(4) A charitable organization that issues qualified charitable gift annuities shall notify the department in writing within ninety (90) days after the effective date of this section, or on the date on which it enters into the organization's first qualified charitable gift annuity agreement, whichever is later. Notice to the department must:

- (a) Be signed by the officer or director of the charitable organization;
- (b) Identify the charitable organization;
- (c) Certify that:
 - (i) The organization is a charitable organization;
 - (ii) The annuities issued by the charitable organization are qualified charitable gift annuities as defined in this section.

The organization shall not be required by the department to submit additional information except to enable the department to determine appropriate penalties that may be applicable under subsection (5) of this section.

(5) The failure of a charitable organization to comply with the notice requirements imposed by this section does not prevent a charitable gift annuity that otherwise meets the requirements of this section from constituting a qualified charitable gift annuity. However, the director of the department may enforce performance of the notice requirements of this section by sending a letter by certified mail, return receipt requested, demanding that the charitable organization comply with the requirements of subsections (3) and (4) of this section. The department may fine the charitable organization in an amount not to exceed one thousand dollars (\$1,000) per qualified charitable gift annuity agreement issued until the charitable organization complies with subsections (3) and (4) of this section.

(6) It is hereby declared that the issuance of a qualified charitable gift annuity does not constitute an unfair or deceptive act or practice in the conduct of trade or commerce prohibited by chapter 6, title 48, Idaho Code.

History.

I.C., § 41-120, as added by 1996, ch. 409, § 2, p. 1354.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Compiler's Notes.

For more on the city index of the consumer price index, referred to in paragraph (1)(c), see <https://www.bls.gov/news.release/cpi.toc.htm>.

The phrase “the effective date of this section” in the introductory paragraph in subsection (4) refers to the effective date of S.L. 1996, ch. 409, § 2, which was effective July 1, 1996.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-121. Exemption of health care sharing ministries from the insurance code. — (1) A health care sharing ministry shall not be considered to be engaging in the business of insurance for purposes of this title.

(2) As used in this section, “health care sharing ministry” means a faith-based nonprofit organization that is tax exempt under the Internal Revenue Code which:

- (a) Limits its participants to those who are of a similar faith;
- (b) Acts as a facilitator among participants who have financial or medical needs and matches those participants with other participants with the present ability to assist those with financial or medical needs in accordance with criteria established by the health care sharing ministry;
- (c) Provides for the financial or medical needs of a participant through contributions from one (1) participant to another;
- (d) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;
- (e) Provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution; and
- (f) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance: “Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or

whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills.”

(3) It is hereby declared that participation in or operation of a health care sharing ministry does not constitute an unfair or deceptive act or practice in the conduct of trade or commerce prohibited by chapter 6, title 48, Idaho Code.

History.

I.C., § 41-121, as added by 2013, ch. 156, § 2, p. 369.

STATUTORY NOTES

Federal References.

The Internal Revenue Code, referred to in subsection (2), is codified as 26 U.S.C.S. § 1 et seq.

Compiler’s Notes.

Section 1 of S.L. 2013, ch. 156 provided: “Short title. This act shall be known as the ‘Health Care Sharing Ministries Freedom to Share Act.’”

Section 3 of S.L. 2013, ch. 156 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

Chapter 2

THE DEPARTMENT OF INSURANCE

Sec.

41-201. Department of insurance.

41-202. Director — Appointment — Term — Qualifications.

41-203. Terms construed.

41-204. Director's oath and bond.

41-205. Official seal.

41-206. Divisions and employees.

41-207. Delegation of powers.

41-208. Prohibited interests, rewards.

41-209. Professional services.

41-210. General powers, duties.

41-211. Rules.

41-212. Orders, notices.

41-213. Enforcement.

41-214. Records — Reproduction — Destruction.

41-215. Use of reproductions and certified copies as evidence.

41-216. Director's annual report.

41-217. Publications authorized.

41-218. Publications — Sale.

41-219. Examination of insurers.

41-220. Examination of agents, brokers, consultants, managers, adjusters, promoters.

41-221. Place of examination.

41-222. Examination cooperation with other states.

41-223. Conduct of examination — Access to records — Correction of accounts — Removal of records.

41-224. Examination — Appraisal of asset.

41-225. Obstruction of examination — Penalty.

41-226. Examiners — Qualifications.

41-227. Examination report.

41-228. Examination expense.

41-229. Witnesses and evidence.

41-230. Testimony compelled — Immunity from prosecution.

41-231. Hearings and appeal — Scope of provisions.

41-232. Hearings in general.

41-232A. Hearings upon the denial, nonrenewal, suspension or revocation of a certificate of authority or license or imposition of administrative penalties.

41-233. Stay of action. [Repealed.]

41-234. Place of hearing — Admission of public.

41-235. Notice of hearing.

41-236. Show cause notice.

41-237. Adjourned hearing.

41-238. Nonattendance.

41-239. Hearing procedure. [Repealed.]

41-240. Order on hearing.

41-241. Appeals from the director. [Repealed.]

41-242. Method of appeal. [Repealed.]

41-243 — 41-245. Record to court — Hearing the appeal — Stay of action on appeal. [Repealed.]

- 41-246. Appeals to Supreme Court. [Repealed.]
- 41-247. Inquiry powers of director.
- 41-248. Interstate relations.
- 41-249. Sharing of information among governmental agencies and the national association of insurance commissioners.
- 41-250. [Amended and Redesignated.]
- 41-251. Civil liability. [Repealed.]
- 41-252. Cooperation between the director of the department of insurance and the director of the department of law enforcement. [Repealed.]
- 41-253. Statement of purpose — Adoption of international fire code.
- 41-254. Powers and duties of state fire marshal — International fire code, enforcement and regulations — Reports.
- 41-255. Duties of state fire marshal.
- 41-256. Assistants to state fire marshal — Local appeal procedure.
- 41-257. State fire marshal as chief arson investigation officer.
- 41-258. Report of losses by fire insurance companies to state fire marshal.
- 41-259. Inspection of buildings — Order of remedy or removal — Service of order.
- 41-260. Appeal from order of remedy or removal — Appeal from local appeal decision.
- 41-261. Failure to comply with order of remedy or removal — Failure to comply with local decision or local appeal decision — Penalty — Civil action to recover penalty.
- 41-262. Failure to comply with order of remedy or removal — Repair or demolition of premises — Expense.
- 41-263. Failure to pay expense of repair or demolition — Assessment.
- 41-264. Investigative hearings — Subpoena of witnesses — Conduct of hearing.
- 41-265. Witness fees — Charge for service of process.

41-266. Admission of international fire code in evidence.

41-267. Hardship resulting from application of act — Adjustments and variances. [Repealed.]

41-268. Arson, fire and fraud prevention account.

41-269. Liberal construction of act.

41-270. [Amended and Redesignated.]

41-271. [Amended and Redesignated.]

41-272. [Amended and Redesignated.]

41-273. [Amended and Redesignated.]

41-274. [Amended and Redesignated.]

41-275. [Reserved.]

41-276 — 41-285. Underground Storage Tank Technician Certification Act. [Repealed.]

41-286. Uniform claims processing.

41-287. Application of provisions adopted by national association of insurance commissioners.

41-288. Retaliatory requirement.

41-290. Fraudulent claims.

41-291. Definitions.

41-292. Disclosure of information by insurers.

41-293. Insurance fraud.

41-294. Damage to or destruction of insured property.

41-295. Duties of the investigation section.

41-296. Confidentiality — Compulsory testimony.

41-297. Disclosure requirements.

41-298. Jurisdiction — Construction of provisions.

§ 41-201. Department of insurance. — There is hereby created the department of insurance of the state of Idaho. The department shall, for the purposes of [section 20, article IV, of the Constitution](#) of the state of Idaho, be an executive department of the state government. The department of insurance shall be composed of such divisions and units as authorized by the provisions of [section 41-206, Idaho Code](#).

History.

1961, ch. 330, § 18, p. 645; am. 1974, ch. 11, § 1, p. 60; am. 1981, ch. 264, § 1, p. 560; am. 1995, ch. 135, § 1, p. 585.

STATUTORY NOTES

Cross References.

Supreme Court reports to be distributed to department of insurance, § 1-505.

Compiler's Notes.

The first insurance law was enacted by S.L. 1901, p. 165. The law was entirely rewritten by S.L. 1911, ch. 225, p. 710, and ch. 228, p. 732, all former enactments being expressly repealed. The law as enacted in S.L. 1911, and reenacted in Compiled Laws, created an insurance department and provided for the appointment of an insurance commissioner and a deputy. S.L. 1919, ch. 8, § 51, p. 69, repealed C.L. 220:1-7, 11-13; § 38 of the same act abolished the insurance department and the offices of the insurance commissioner and his deputy, and § 28 vested their powers and duties in the department of commerce and industry.

S.L. 1921, ch. 104, § 7 amended § 28 by conferring on the department of finance the rights, powers and duties vested by law in the department of commerce and industry.

S.L. 1947, ch. 61, § 1, amended C.L. 220:8 by recreating the office of commissioner of insurance and investing in said officer all the rights, powers and duties vested formerly in the commissioner of finance and the director of the bureau of insurance.

The insurance laws were again entirely rewritten by S.L. 1961, ch. 330 which provided for a department of insurance and a commissioner of insurance.

In 1974, commissioner of insurance was changed to director by S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Cited *Liberty Nat'l Ins. Co. v. Reinsurance Agency, Inc.*, 307 F.2d 164 (9th Cir. 1962).

§ 41-202. Director — Appointment — Term — Qualifications. — (1)

The director of the department of insurance shall be the chief executive officer of the department of insurance.

(2) The director shall be appointed by the governor and shall hold office for a term of four (4) years, subject to earlier removal by the governor. A vacancy in the office of director shall be filled for the balance of the unexpired term only.

(3) The governor shall not appoint as director any individual, and no individual shall hold the office of director, who is not qualified therefor as follows: (a) Must be a qualified elector of the state of Idaho; and (b) Must have had at least five (5) years' practical experience in one or more of the types of insurance business subject to regulation by the director, or have had other professional or business experience reasonably adequate in character and scope to equip him to discharge the duties and fulfill the responsibilities of the office of director.

History.

1961, ch. 330, § 19, p. 645; am. 1974, ch. 11, § 2, p. 60.

§ 41-203. Terms construed. — Wherever the words “commissioner of insurance” or “insurance commissioner” appear in title 41, Idaho Code, or elsewhere in the Idaho Code, they shall be understood and construed to mean the director of the department of insurance.

History.

1961, ch. 330, § 20, p. 645; am. 1974, ch. 11, § 3, p. 60.

STATUTORY NOTES

Effective Dates.

Section 4 of S.L. 1974, ch. 11 provided the act should take effect on and after July 1, 1974.

§ 41-204. Director's oath and bond. — At the time of taking office the director shall take an oath of office, and give bond in favor of the state of Idaho in the time, form and manner prescribed in chapter 8, title 59, Idaho Code. The oath shall be filed with the secretary of state.

History.

1961, ch. 330, § 21, p. 645; am. 1969, ch. 214, § 1, p. 625; am. 1971, ch. 136, § 28, p. 522.

STATUTORY NOTES

Cross References.

Secretary of state, § 67-901 et seq.

Oath of office, § 59-401.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-205. Official seal. — (1) The director shall have an official seal, in the form and design as so in use immediately prior to the effective date of this code.

(2) The director shall issue under his official seal all certificates, other than licenses of agents, brokers, adjusters, and other insurance representatives, to be issued by him under the laws of this state.

History.

1961, ch. 330, § 22, p. 645.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Compiler's Notes.

In this section “commissioner” has been changed to “director” by the code commission on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase “the effective date of this code” at the end of subsection (1) refers to the effective date of S.L. 1961, Chapter 330, which was effective January 1, 1962.

§ 41-206. Divisions and employees. — (1) The department shall be organized into such divisions and such other units as may be administratively established in order to efficiently administer the department. Each division shall be headed by a division administrator who shall be appointed by and serve at the pleasure of the director, and shall be a nonclassified employee exempt from the provisions of chapter 53, title 67, Idaho Code.

(2) The director may pursuant to chapter 53, title 67, Idaho Code, appoint, employ, fix the compensation of, prescribe and require the duties of and discharge such employees as the duties of his office may require.

(3) The director may contract for and procure on a basis of fee and without giving such persons any status as an employee of this state, such independently contracting actuarial, technical, examining, and other similar professional services as the director may from time to time require for the discharge of his duties.

History.

I.C., § 41-206, as added by 1981, ch. 264, § 3, p. 560; am. 1995, ch. 135, § 2, p. 585.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Prior Laws.

Former § 41-206, (1961, ch. 330, § 23, p. 645; am. 1969, ch. 214, § 2, p. 625; am. 1971, ch. 136, § 29, p. 522), was repealed by S.L. 1981, ch. 264, § 2.

§ 41-207. Delegation of powers. — (1) The director may delegate to his deputy, assistant, counsel, actuary, examiner or employee, the exercise or discharge in the director's name of any power, duty, or function, whether ministerial, discretionary or of whatever character, vested in or imposed upon the director under this code.

(2) The official act of any such person so acting in the director's name and by his authority shall be deemed to be an official act of the director.

History.

1961, ch. 330, § 24, p. 645.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-208. Prohibited interests, rewards. — (1) The director or any deputy, actuary, examiner, assistant or employee of the director shall not be a director, officer, or employee of any insurer or be financially interested in the business of any insurer, except as a policyholder or claimant under an insurance policy or by reason of rights theretofore vested in commissions, fees, or retirement benefits related to services theretofore performed; nor shall any such individual engage in any other business or occupation interfering with or inconsistent with the duties of his office or employment, or serve on or under any political committee or take an active part in any political campaign on behalf of any candidate or party; that as to matters wherein a conflict of interests does not exist on the part of any such individual, the director may employ or retain from time to time insurance actuaries, examiners, accountants, attorneys or other technicians who are independently practicing their professions even though from time to time similarly employed or retained by insurers or others.

(2) Except as provided in section 41-209[, Idaho Code], no person shall directly or indirectly give or pay to the director, or any deputy, actuary, examiner, assistant or employee of the director, and the director or his deputy, actuary, examiner, assistant or employee shall not directly or indirectly receive or accept, any fee, compensation, loan, gift, or other thing of value in addition to the compensation and expense allowance provided by law, for any service rendered or to be rendered as such director, deputy, actuary, examiner, assistant or employee or in connection therewith, or for services rendered or to be rendered in relation to legislation, or for extra services rendered or to be rendered, or for any cause whatsoever related, to any person who is subject to the supervision of the director under this code.

(3) Subsections (1) and (2) shall not be deemed to prohibit: (a) Receipt by any such individual of fully vested commissions or fully vested retirement benefits to which he is entitled by reason of services performed prior to becoming director or prior to employment by the director; or (b) Investment in shares of regulated diversified investment companies; or (c) Mortgage loans made under customary terms and in the ordinary course of business.

History.

1961, ch. 330, § 25, p. 645; am. 1969, ch. 214, § 3, p. 625.

STATUTORY NOTES**Compiler's Notes.**

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the beginning of subsection (2) was added by the compiler to conform to the statutory citation style.

§ 41-209. Professional services. — (1) Upon a domestic insurer's written request to the director, the director may authorize an examiner, actuary, or other insurance technician appointed or employed by the director, to render to the insurer such professional or technical services as may not otherwise be reasonably obtainable from professional sources within this state.

(2) Compensation for services so actually rendered shall be in such reasonable amount as may be agreed upon between the insurer and the individual performing the services. Such individual shall file a copy of his statement for services with the director before delivery of the same to the insurer or payment thereof.

History.

1961, ch. 330, § 26, p. 645.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-210. General powers, duties. — (1) The director shall enforce the provisions of this code, and shall execute the duties imposed upon him by this code.

(2) The director shall have the powers and authority expressly conferred upon him by or reasonably implied from the provisions of this code.

(3) The director may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he may deem proper to determine whether any person has violated any provision of this code or to secure information useful in the lawful administration of any such provision. The cost of such additional examinations and investigations shall be borne by the state.

(4) For any document required to be filed with the director or the department of insurance under the laws of this state, the director may specify the place and manner of filing of the document, including whether an electronic or paper filing is required or acceptable.

(5) The director shall have such additional powers and duties as may be provided by other laws of this state.

History.

1961, ch. 330, § 27, p. 645; am. 2004, ch. 238, § 1, p. 701.

STATUTORY NOTES

Cross References.

Director of department of insurance, § 41-202.

Worker's compensation, assigned risk system, duties, § 72-322.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Authority.

Director.

Police power.

Authority.

Employment service provider that offered a variety of services to small businesses, including insurance services, was a multiple employer welfare arrangement (MEWA), as defined by 29 U.S.C.S. § 1002(40), because it offered health benefits to two or more employers; thus, it violated the Idaho Code by transacting the business of insurance without a certificate of authority. Idaho department of insurance had the authority to enforce the provisions of the Idaho Code and to regulate and investigate insurance matters, and nothing precluded that grant of authority from extending to MEWAs. *Emplrs Res. Mgmt. Co. v. Dep't of Ins.*, 143 Idaho 179, 141 P.3d 1048 (2006), overruled on other grounds, *Verska v. St. Alphonsus Med. Ctr.*, 151 Idaho 889, 265 P.3d 502 (2011).

Director.

The insurance code created the office of commissioner of insurance (now director of department of insurance) with broad powers to secure the effective administration of the insurance laws, and all of the regulations contained therein were primarily intended to effect the protection of the people, and to promote their general welfare in relation to insurance. The police regulations therein contained were to be so construed and applied by the commissioner (now director) as to attain that purpose, without unnecessary limitations upon the constitutional rights of the parties involved, and with a minimum interference with the free exercise of such rights. *Gem State Mut. Life Ins. Assn. v. O'Connell*, 79 Idaho 427, 320 P.2d 329 (1957).

Police Power.

The business of insurance is affected with a public interest and is subject to regulation by the state in exercise of its police power. *Gem State Mut. Life Ins. Assn. v. O'Connell*, 79 Idaho 427, 320 P.2d 329 (1957).

§ 41-211. Rules. — (1) The director may make reasonable rules necessary for or as an aid to the effectuation of any provision of this code. No such rule shall extend, modify, or conflict with any law of this state or the reasonable implications thereof.

(2) Any such rule affecting persons or matters other than the personnel or the internal affairs of the department shall be made or amended in accordance with the provisions of chapter 52, title 67, Idaho Code.

(3) In addition to any other penalty provided, wilful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

History.

1961, ch. 330, § 28, p. 645; am. 1994, ch. 310, § 1, p. 976.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 2 of S.L. 1994, ch. 310 declared an emergency and provided this act shall be in full force and effect on and after March 31, 1994 and retroactively to July 1, 1993. Approved March 31, 1994.

CASE NOTES

Limitation on Rules.

Plain text of § 41-1042 permits a bail bond company to contemporaneously write a bail bond and contract with a client to indemnify the company for the cost of apprehending a defendant who jumps bail. [Idaho Admin. Code R. 18.01.04.016.02](#), which forbids such contracts, contravenes the statute and prejudices the company's substantial

right to contract freely, contrary to § 67-5279. *Two Jinn, Inc. v. Idaho Dep't of Ins.*, 154 Idaho 1, 293 P.3d 150 (2013).

§ 41-212. Orders, notices. — (1) Orders and notices of the director shall be effective only when in writing signed by him or by his authority.

(2) Every such order shall state its effective date, and shall concisely state: (a) Its intent or purpose.

(b) The grounds on which based.

(c) The provisions of this code pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the director of the right to rely thereon.

(3) Except as may be provided in this code respecting particular procedures, an order or notice may be given by: (a) Personal service upon the person to be ordered or notified; (b) Mailing it, postage prepaid, by regular United States mail, or by certified mail, return receipt requested, addressed to the person at his residence or principal place of business as last of record in the department; or (c) Where a party has appeared in a contested case or has not yet appeared but has consented or agreed in writing to service by facsimile transmission (FAX) or e-mail as an alternative to personal service or service by mail, such orders or notices may be served by FAX or by e-mail in lieu of service by mail or personal service.

(4) Service of orders and notices is complete when a copy is personally served upon the person to be served, or when a copy properly addressed and postage prepaid is deposited in the United States mail or the statehouse mail, if the person is a state employee or state agency, or when there is an electronic verification that a FAX or an e-mail has been sent.

History.

1961, ch. 330, § 29, p. 645; am. 2012, ch. 157, § 1, p. 433.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 157, in subsection (3), divided the existing provisions into an introductory paragraph and present paragraphs (a) and (b), deleted “delivery to” at the end of the introductory paragraph, added “Personal service upon” in paragraph (a), substituted the present provisions in paragraph (b) for “mailing it, postage prepaid, addressed to him at his residence or principal place of business as last of record in the department. Notice so mailed shall be deemed to have been given when deposited in a letter depository of a United States post office”, and added paragraph (c); and added subsection (4).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The abbreviation in parentheses so appeared in the law as enacted.

§ 41-213. Enforcement. — (1) The director may institute such suits or other lawful proceedings as he may deem necessary for the enforcement of any provision of title 41, Idaho Code. If the director believes that any person has engaged in or is about to engage in any act or practice constituting a violation of any provision of title 41, Idaho Code, any other law the director has authority to enforce, or any rule or order of the director, the director may, in accordance with the procedures set forth in title 41, Idaho Code, and chapter 52, title 67, Idaho Code:

- (a) Issue an order requiring the person to cease and desist from any prohibited act or practice;
- (b) Issue an order affecting a person's license for such reasons as set forth in title 41, Idaho Code;
- (c) Issue an order imposing an administrative penalty as provided in title 41, Idaho Code; and
- (d) Initiate any action in district court for the same relief or any relief authorized by title 41, Idaho Code.

(2) If the director believes that any person is violating or about to violate any provision of title 41, Idaho Code, or any order or requirement of the director issued or promulgated pursuant to authority expressly granted the director by any provision of title 41, Idaho Code, or by other law, the director may bring an action against such person in the name of the people of the state of Idaho in a district court of this state to enjoin such person from continuing such violation or doing any act in furtherance thereof. In the action the court may enter such order or judgment granting such preliminary or final injunction as the court determines to be proper.

(3) If the director has reason to believe that any person has violated any provision of title 41, Idaho Code, or any provision of other law as applicable to insurance operations, for which criminal prosecution is provided and would be in order, he shall give the information relative thereto to the attorney general or county attorney having jurisdiction of any such violation. The attorney general or county attorney shall promptly

institute such action or proceedings against such person as the information may require or justify.

(4) Whenever the director may deem it necessary, he shall employ counsel, or call upon the attorney general of this state for legal counsel and such assistance as may be necessary.

History.

1961, ch. 330, § 30, p. 645; am. 1972, ch. 369, § 2, p. 1072; am. 2005, ch. 78, § 1, p. 78.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Director of department of insurance, § 41-202.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-214. Records — Reproduction — Destruction. — (1) The director shall preserve in permanent form records of his proceedings and hearings and including a concise statement of the results of any investigations or examinations of insurers, and shall file such records in the department.

(2) The records and insurance filings in the department shall be open to public inspection, except as otherwise provided by this code.

(3) The director may photograph, microphotograph or reproduce on film, whereby each page will be reproduced in exact conformity with the original except as to dimensions, financial statements of insurers, reports of business transacted in this state by foreign insurers, reports of examination of insurers, and such records and documents on file in his office as he may in his discretion select.

(4) The director may destroy unneeded or obsolete records and filings of the department in accordance with provisions and procedures applicable to administrative agencies of this state in general.

History.

1961, ch. 330, § 31, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-215. Use of reproductions and certified copies as evidence. — (1) Photographs or microphotographs in the form of film or prints of documents and records made under section 41-214(3)[, Idaho Code,] shall have the same force and effect as the originals thereof, and duly certified or authenticated reproductions of such photographs or microphotographs shall be as admissible in evidence as are the originals.

(2) Upon request of any person and payment of the applicable fee, the director shall furnish a certified copy of any record in his office which is then subject to public inspection.

(3) Copies of original records or documents in his office certified by the director shall have the same effect and force and be received in evidence in all courts equally and in like manner as if they were originals.

History.

1961, ch. 330, § 32, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-216. Director's annual report. — As early after July 1 as is consistent with full and accurate preparation the director annually shall transmit to the governor a report of his official transactions containing with respect to the calendar year next preceding:

(1) A list of all authorized insurers transacting insurance in this state, showing as to each insurer the name, location, amount of capital (if a stock insurer) or surplus (if a mutual or reciprocal insurer), date of incorporation or formation, date of commencement of business, and kinds of insurance transacted.

(2) A condensed form of financial statements and reports of every authorized insurer for the calendar year, as audited and corrected by the director, arranged in tabular form or in abstracts.

(3) A list of insurers whose business in this state was terminated and the reason for such termination; and if such termination was a result of liquidation, or of delinquency proceedings brought against the insurer in this or any other state, the amount of the insurer's assets and liabilities so far as the same are known to the director.

(4) A statement of the operating expenses of the department, including salaries, transportation, communication, printing, office supplies, fixed charges (insurance and bonds) and miscellaneous expense.

(5) A detailed statement of the moneys and fees received by the department and from what source.

(6) Any recommendations for amendments or supplementations to insurance laws which, in the director's opinion, may be desirable.

(7) Such other pertinent information and matters as the director deems to be in the public interest.

History.

1961, ch. 330, § 34, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-217. Publications authorized. — The director shall publish, by printing or other suitable form of reproduction:

(1) Pamphlet or booklet copies of the insurance laws of this state; (2) The director's annual report; (3) Such copies of results of investigations or examinations of insurers for public distribution as he deems to be in the public interest; (4) Such compilations as he deems advisable from time to time of the general orders of the director then in force; and (5) Such other material as he may compile and deem relevant and suitable for the more effective administration of this code.

History.

1961, ch. 330, § 34, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-218. Publications — Sale. — (1) The director shall fix a price at not less than cost of distribution and printing or other reproduction, to be paid by persons requesting copies of the insurance laws and such other publications referred to in section 41-217[, Idaho Code,] as he deems proper to sell on behalf of the state rather than distribute free of charge on a basis of reciprocity.

(2) The director shall account for and deposit all moneys so received in the same manner as applies under section 41-406[, Idaho Code,] to fees and taxes collected by him.

History.

1961, ch. 330, § 35, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in subsections (1) and (2) were added by the compiler to conform to the statutory citation style.

§ 41-219. Examination of insurers. — (1) For the purpose of determining its financial condition, ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, and compliance with the law, the director shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer, including the attorney in fact of a reciprocal insurer in so far as insurer transactions are concerned, as often as he deems advisable. The director or any of the director's examiners may conduct an examination, in accordance with the provisions of this section, of any company as often as the director in his sole discretion deems appropriate but shall, at a minimum, conduct an examination of every insurer licensed in this state not less frequently than once every five (5) years. In scheduling and determining the nature, scope and frequency of the examinations, the director shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the examiners' handbook adopted by the national association of insurance commissioners and in effect when the director exercises discretion under the provisions of this section.

(2) Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the director.

(3) The director shall in like manner examine each insurer applying for an initial certificate of authority to transact insurance in this state.

(4) In lieu of an examination under the provisions of this section, of any foreign or alien insurer licensed in this state, the director may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port of entry until January 1, 1994. Thereafter, such reports may only be accepted if the insurance department was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program or, the examination is performed under the supervision of an accredited insurance department or with participation

of one (1) or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(5) The term “company” as used in this section shall mean any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the director.

History.

1961, ch. 330, § 36, p. 645; am. 1993, ch. 194, § 1, p. 492.

STATUTORY NOTES

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

As to national association of insurance commissioners, referred to in subsections (1) and (4), see <http://naic.org>

As to NAIC financial regulations standards and accreditation program, referred to in subsection (4), see www.naic.org/documents/cmtffrsapamphlet.pdf.

§ 41-220. Examination of agents, brokers, consultants, managers, adjusters, promoters. — For the purpose of ascertaining compliance with law, and in addition to any right of examination otherwise provided, the director may as often as he deems advisable examine the accounts, records, documents, and transactions, pertaining to or affecting its insurance affairs or proposed insurance affairs, of:

(1) any insurance agent, broker, solicitor, consultant, surplus line broker, general agent, or adjuster.

(2) Any person[s] having a contract under which he enjoys in fact the exclusive or dominant right to manage or control an insurer.

(3) Any person holding the shares of voting stock or policyholder proxies of a domestic insurer, for the purpose of controlling the management thereof, as voting trustee or otherwise.

(4) Any person engaged in this state in, or proposing to be engaged in this state in, or holding himself out in this state as so engaging or proposing, or in this state assisting in, the promotion or formation of an insurer or insurance holding corporation, or corporation to finance an insurer or the production of its business.

History.

1961, ch. 330, § 37, p. 645; am. 1972, ch. 369, § 3, p. 1072.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed “s” in subsection (2) was inserted by the compiler to denote that the “s” is surplusage in that sentence.

§ 41-221. Place of examination. — (1) The examination may be conducted by the director or his accredited examiners at the offices wherever located of the person being examined and at such other places as may be required for determination of matters under examination.

(2) In the case of alien insurers the examination may be so conducted in the insurer's United States offices and at places within the United States, except as otherwise required by the director.

History.

1961, ch. 330, § 38, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-222. Examination cooperation with other states. — As far as practical the director shall conduct the examination of a foreign or alien insurer in cooperation with the insurance supervisory officials of other states in which the insurer transacts business, and for the purpose thereof may participate in joint examinations of insurers or be represented in an examination by an examiner of another state.

History.

1961, ch. 330, § 39, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-223. Conduct of examination — Access to records — Correction of accounts — Removal of records. — (1) Upon determining that an examination should be conducted, the director or the director's designee shall issue an examination warrant appointing one (1) or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the examiners' handbook adopted by the national association of insurance commissioners. The director may also employ such other guidelines or procedures as the director may deem appropriate.

(2) Upon such examination the director or examiner may examine under oath any officer, agent, or other individual deemed to have material information regarding the affairs of the person under examination.

(3) Every person being examined, its officers, attorneys, employees, agents, representatives or others having custody or control thereof, shall make freely available to the director or his examiners the accounts, records, documents, files, information, assets and matters in his possession or control relating to the subject of the examination, and shall facilitate the examination.

(4) If the director finds any accounts or records to be inadequate or incorrectly kept or posted, he may procure the services of competent persons to reconstruct, rewrite, post or balance them at the expense of the person being examined if such person has failed to maintain, complete or correct such records or accounts after the director has given him notice and a reasonable opportunity to do so.

(5) Neither the director nor any examiner shall remove any record, account, document, file or other property of the person being examined from the offices of such person except with the written consent of such person being given in advance of such removal, or pursuant to an order of court duly obtained. This provision shall not be deemed to affect the making and removal of copies or abstracts of any such record, account, document, or file.

(6) Nothing contained in this chapter shall be construed to limit the director's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state.

(7) Nothing contained in this chapter shall be construed to limit the director's authority to use any final examination report, or to use any examiner or company work papers or other documents, or any other information discovered or developed during the course of any examination in any judicial proceeding or administrative proceeding under this chapter.

History.

1961, ch. 330, § 40, p. 645; am. 1993, ch. 194, § 2, p. 492; am. 1995, ch. 136, § 1, p. 587.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

As to national association of insurance commissioners, referred to in subsection (1), see *<http://naic.org>*.

§ 41-224. Examination — Appraisal of asset. — (1) If the director deems it necessary to value any asset involved in such an examination, he may make written request of the person being examined to appoint one or more appraisers who by reason of education, experience or special training are competent to appraise such asset. Any such appraiser shall be subject to the written approval of the director. If no such appointment is made within ten (10) days after the request therefor was delivered to such person, the director may appoint the appraiser or appraisers.

(2) Any such appraisal shall be promptly made, and a copy of the report thereof shall be furnished to the director.

(3) The reasonable expense of the appraisal shall be borne by the person being examined.

History.

1961, ch. 330, § 41, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-225. Obstruction of examination — Penalty. — Any individual who wilfully obstructs the director or his examiner in the conduct of any examination authorized by this chapter shall be guilty of a misdemeanor and upon conviction shall be punished as provided in section 41-117[, Idaho Code] (general penalty).

History.

1961, ch. 330, § 42, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of the section was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-226. Examiners — Qualifications. — For the conduct of or assistance in examinations under this chapter the director shall appoint as examiners only individuals who by reason of education, experience, or special training are competent to perform the duties and fulfill the responsibilities of an insurance examiner. In the selection of examiners the director shall give due consideration to standards and qualifications therefor recommended by the National Association of Insurance Commissioners or any successor organization thereto. The director may appoint, employ, fix the compensation of, prescribe and require the duties of and discharge such examiners as the duties of his office may require. Examiners who are employees of the department shall be nonclassified employees exempt from the provisions of chapter 53, title 67, Idaho Code.

History.

1961, ch. 330, § 43, p. 645; am. 1995, ch. 135, § 3, p. 585; am. 2003, ch. 99, § 1, p. 318.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

As to national association of insurance commissioners, referred to in this section, see *<http://naic.org>*.

Effective Dates.

Section 4 of S.L. 1995, ch. 135 declared an emergency. Approved March 15, 1995.

CASE NOTES

Decisions Under Prior Law Examiner State Employee.

Insurance examiner appointed by state for the purpose of conducting examinations of foreign insurance companies was a state employee, though

earnings were received from the companies examined. [Barraclough v. State Tax Comm'n](#), 75 Idaho 4, 266 P.2d 371 (1954).

§ 41-227. Examination report. — (1) The director or his examiner shall make a full and true written report of every examination made by him under this chapter, and shall verify the report by his oath.

(2) The report shall comprise only facts appearing upon the books, papers, records or documents of the person being examined, or ascertained from testimony of individuals under oath concerning the affairs of such person, together with such conclusions and recommendations as may reasonably be warranted from such facts.

(3) Prior to a hearing and prior to any modifications the report shall be subject to disclosure according to chapter 1, title 74, Idaho Code.

(4) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(5) Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the director shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's work papers, and enter an order:

(a) Adopting the examination report as filed or with modifications or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the director, the director may order the company to take any action the director considers necessary and appropriate to cure such violation;

(b) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refile pursuant to subsection (2)[(4)] of this section; or

(c) Calling for an investigatory hearing with no less than twenty (20) days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(6)(a) All orders entered pursuant to subsection (5)(a) of this section shall be accompanied by findings and conclusions resulting from the director's consideration and review of the examination report, relevant examiner work papers and any written submissions or rebuttals. Any such order shall be considered a final order and may be appealed pursuant to [sections 67-5270 through 67-5279, Idaho Code](#), and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(b) Any hearing conducted under subsection (5)(c) of this section by the director or authorized representative, shall be conducted in accordance with the provisions of chapter 52, title 67, Idaho Code, as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by, or as a result of, the director's review of relevant work papers or by the written submission or rebuttal of the company. Within twenty (20) days of the conclusion of any such hearing, the director shall enter an order pursuant to the provisions of subsection (5)(a) of this section.

(c) The director shall not appoint a contract examiner or an employee of the department as an authorized representative to conduct the hearing. Nothing contained in this section shall require the department to disclose any information or records which would indicate or show the content of any investigation or activity of a criminal justice agency, except to the extent that the director relied upon information furnished to the director by such criminal justice agency in making his decision.

(7) The report when so verified and filed shall be admissible in evidence in any action or proceeding brought by the director against the person examined, or against its officers, employees or agents, and shall be presumptive evidence of the material facts stated therein. The director or his

examiners may at any time testify and offer other proper evidence as to information secured or matters discovered during the course of an examination, whether or not a written report of the examination has been either made, furnished or filed in the department.

(8) After an order is entered under the provisions of subsection (5)(a) of this section, the director may publish the report or the results of the examination as contained therein which report or results are a public record and shall be exempt from the exemptions from disclosure provided in chapter 1, title 74, Idaho Code.

(9) Nothing contained in this chapter shall prevent or be construed as prohibiting the director from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as the agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this chapter.

(10) All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the director or any other person in the course of an examination made under the provisions of this chapter shall be made available to the person or company which was the subject of the examination in proceedings pursuant to chapter 52, title 67, Idaho Code, but shall otherwise be held by the director as a record not required to be made public pursuant to exemptions from disclosure provided in chapter 1, title 74, Idaho Code.

History.

1961, ch. 330, § 44, p. 645; am. 1990, ch. 213, § 52, p. 480; am. 1993, ch. 194, § 3, p. 492; am. 1995, ch. 136, § 2, p. 587; am. 1996, ch. 95, § 1, p. 280; am. 1999, ch. 30, § 10, p. 41; am. 2015, ch. 141, § 105, p. 379.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in subsections (3), (8), and (10).

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in paragraph (5)(b) was added by the compiler to correct the internal reference, as subsection (4) of this section relates to the filing of reports.

Section 37 of S.L. 1993, ch. 194 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

§ 41-228. Examination expense. — (1) Every insurer or corporation so examined shall, at the direction of the director, pay the actual travel expenses, reasonable living expense allowance, and compensation, at reasonable rates customary for such examination and as approved by the director, necessarily incurred on account of the examination, upon presentation of a detailed account of such charges and expenses.

(2) No person shall pay and no examiner shall accept any additional emolument on account of any examination.

(3) An insurer shall be entitled to offset against its premium taxes payable to the department of insurance of the state of Idaho the examination expense paid by it to or for the account of an examiner, actuary, or other assistant designated by the director for the purpose of the examination, inclusive of such personnel as may be so designated on behalf of other states participating in any such examination. The offset, or any remaining portion thereof, will be allowed for any of the five (5) calendar years following the year in which such examination expense was paid.

History.

1961, ch. 330, § 45, p. 645; am. 1969, ch. 214, § 4, p. 625; am. 1975, ch. 207, § 1, p. 575; am. 1980, ch. 133, § 1, p. 292; am. 1984, ch. 100, § 1, p. 228; am. 1994, ch. 267, § 1, p. 825; am. 2001, ch. 85, § 1, p. 211.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Decisions Under Prior Law Examiner State Employee.

Insurance examiner appointed by state for the purpose of conducting examinations of foreign insurance companies was a state employee, though

earnings were received from the companies examined. [Barraclough v. State Tax Comm'n](#), 75 Idaho 4, 266 P.2d 371 (1954).

§ 41-229. Witnesses and evidence. — (1) As to the subject of any examination, investigation, or hearing being conducted by him the director or any deputy or examiner appointed by him may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and testimony, and require by subpoena the production of books, papers, records, files, correspondence, documents and other evidence which he deems relevant to the inquiry.

(2) If any individual refuses to comply with any such subpoena or to testify as to any matter concerning which he may be lawfully interrogated, the district court of the county wherein such examination, investigation, or hearing is being conducted or of the county wherein such individual resides, on the director's application may issue an order requiring such individual to comply with the subpoena and to testify; and failure to obey such an order may be punished by the court as a contempt thereof.

(3) Subpoenas shall be served, and proof of such service made, in the same manner as if issued by a district court. Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a district court.

(4) Any individual wilfully testifying falsely under oath as to any matter material to any such examination, investigation or hearing shall upon conviction thereof be guilty of perjury and shall be punished accordingly.

History.

1961, ch. 330, § 46, p. 645.

STATUTORY NOTES

Cross References.

Contempt proceedings, § 7-601 et seq.

Perjury, § 18-5401 et seq.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-230. Testimony compelled — Immunity from prosecution. — (1)

If any person asks to be excused from attending or testifying or from producing any books, papers, records, contracts, documents, or other evidence in connection with any examination, hearing, or investigation being conducted by the director, his deputy or examiner, or in any proceeding or action before any court or magistrate upon a charge of violation of this code, on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture, and shall notwithstanding be directed to give such testimony or produce such evidence, he must, if so directed by the director and the attorney general, nonetheless comply with such direction; and he shall not be exempt from the refusal, suspension, or revocation of any license, permission, or authority conferred, or to be conferred, pursuant to this code. After complying, and if, but for this section, he would have been privileged to withhold the answer given or the evidence produced by him, the answer given, or evidence produced, and any information directly or indirectly derived from the answer or evidence, may not be used against the compelled person in any manner in a criminal case, except that he may nevertheless be prosecuted or subjected to penalty or forfeiture for any perjury, false swearing or contempt committed in answering or failing to answer, or in producing or failing to produce, evidence in accordance with the order.

(2) Any such individual may execute, acknowledge and file in the department a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement, and thereupon the testimony of such individual or such evidence in relation to such transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, magistrate, grand jury or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privileges on account of any testimony he may so give or evidence so produced.

History.

1961, ch. 330, § 47, p. 645; am. 2007, ch. 283, § 1, p. 813.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Amendments.

The 2007 amendment, by ch. 283, in subsection (1), substituted “and he shall not be exempt” for “but he shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which he may have so testified or produced evidence, and no testimony so given or evidence produced shall be received against him upon any criminal action, investigation, or proceeding; except however, that no such person so testifying shall be exempt from prosecution or punishment for any perjury committed by him in such testimony, and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation, or proceeding concerning such perjury; nor shall he be exempt,” and added the last sentence.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-231. Hearings and appeal — Scope of provisions. — Except as otherwise provided in title 41, Idaho Code, and to the extent not inconsistent therewith, chapter 52, title 67, Idaho Code, shall apply as to all hearings and as to all appeals from the director relative to any matter treated in this code.

History.

1961, ch. 330, § 48, p. 645; am. 2005, ch. 77, § 1, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-232. Hearings in general. — (1) The director may hold a hearing which he deems necessary for any purpose within the scope of this code.

(2) The director shall hold a hearing: (a) If required by any provision of this code; or (b) Upon written demand for a hearing by a person aggrieved by any act, threatened act or failure of the director to act, or by any report, rule, regulation or order of the director (other than an order for the holding of a hearing, or an order on a hearing of which hearing such person had actual notice or pursuant to such order).

(3) Any such demand for a hearing shall summarize the information and grounds to be relied upon as a basis for the relief to be sought at the hearing.

(4) The director shall hold such demanded hearing within thirty (30) days after his receipt of the demand, unless postponed by mutual consent. Failure to hold the hearing shall constitute a denial of the relief sought, and shall be the equivalent of an order on hearing for the purpose of an appeal.

(5) In any administrative proceeding of the director where a hearing is otherwise authorized or required by law, if a party with respect to whom the hearing is to be held waives the hearing in writing, or fails to plead, or to defend or prosecute, as the case may be, and that fact is made known to the director by affidavit or otherwise, the right of hearing shall be deemed to have been waived, and, any other provision of this code to the contrary notwithstanding, without holding or concluding a hearing the director may, upon satisfactory proof of service of the petition or complaint upon such a party, enter an order which shall be as lawful as to such party as if all allegations in the petition or complaint relative to or concerning such party were proved or admitted at a hearing. For good cause shown, the director may, in his discretion, set aside any order so entered, and the proceedings may continue as if no waiver or default had existed.

History.

1961, ch. 330, § 49, p. 645; am. 1972, ch. 369, § 4, p. 1072; am. 2019, ch. 161, § 7, p. 526.

STATUTORY NOTES

Amendments.

The 2019 amendment, by ch. 161, deleted “under [section 41-241, Idaho Code](#)” at the end of subsection (4).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Exhaustion of Administrative Remedies.

In suit for commissions on contract canceled by rehabilitator appointed by the supreme court during period of rehabilitation of defendant insurance company, where plaintiff did not file a claim or make objection in the supreme court on account of such cancelation nor request a hearing as provided by this section, judgment of approval of such cancelation was binding and plaintiff had no right to raise the question in the federal court. [Liberty Nat’l Ins. Co. v. Reinsurance Agency, Inc., 307 F.2d 164 \(9th Cir. 1962\)](#), cert. denied, [371 U.S. 949, 83 S. Ct. 503, 9 L. Ed. 2d 498 \(1963\)](#).

§ 41-232A. Hearings upon the denial, nonrenewal, suspension or revocation of a certificate of authority or license or imposition of administrative penalties. — (1) In the event the director denies an applicant's application for a certificate of authority or for a license, the director shall notify the applicant in writing of the basis for the denial. Within twenty-one (21) days of the issuance of the notice of denial, the applicant may submit to the director a written request for a hearing before the director or his duly appointed representative addressing the basis for the denial of the application and requesting that the director reexamine the applicant's qualifications for a certificate of authority or a license. An applicant's failure to request a hearing in writing within twenty-one (21) days of the issuance of the notice of denial shall be deemed a waiver of the opportunity for hearing.

(2) Except as otherwise provided in title 41 and chapter 52, title 67, Idaho Code, prior to the director's nonrenewal, suspension or revocation of a certificate of authority or license or imposition of any administrative penalty, the director shall provide the insurer or licensee, and any appointing insurers that have appointed the licensee as an agent, with advance written notice of the nature of the violations alleged or the charges pending against the insurer or licensee and affording the insurer or licensee an opportunity for a hearing thereon. Within twenty-one (21) days of the issuance of the notice of violations or charges, the insurer or licensee may submit to the director a written request for a hearing before the director or his duly appointed representative addressing the alleged violations and charges pending against the insurer or licensee. An insurer's or licensee's failure to request a hearing or otherwise dispute the notice in writing within twenty-one (21) days of the issuance of the notice of violations or charges shall be deemed a waiver of the opportunity for hearing.

(3) All hearings under this section shall be conducted in accordance with the provisions set forth in this chapter and chapter 52, title 67, Idaho Code.

History.

I.C., § 41-232A, as added by 2006, ch. 49, § 1, p. 141.

§ 41-233. Stay of action. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 50, p. 645; am. 1980, ch. 154, § 1, p. 324, was repealed by S.L. 2005, ch. 77, § 2.

§ 41-234. Place of hearing — Admission of public. — The hearing shall be held at the place designated by the director, and at his discretion it may be open to the public.

History.

1961, ch. 330, § 51, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-235. Notice of hearing. — (1) Except where a longer period of notice is provided by other provisions of this code relative to particular matters, not less than fourteen (14) days in advance the director shall give notice of the time and place of the hearing, stating the matters to be considered thereat. If the persons to be given notice are not specified in the provision pursuant to which hearing is held, the director shall give such notice to all persons whose pecuniary interests are to be directly and immediately affected by such hearing.

(2) If any such hearing would otherwise require separate notices to more than one hundred (100) persons, in lieu of the notice required under such subsection the director may give notice of the hearing by publishing the notice in at least three (3), but not to exceed five (5), daily newspapers, at least once each week during the four (4) weeks immediately preceding the week in which the hearing is to be held. The director shall select such newspapers, as to location and circulation, as he deems necessary to give adequate opportunity of notice to such persons as should receive notice of the hearing. The published notice shall state the time and place of the hearing and shall specify the matters to be considered thereat. At the time of first publication the director shall mail to every advisory organization which has filed with him pursuant to [section 41-1425, Idaho Code](#), a copy of the published notice if the proposed hearing would affect any interest of the members of such advisory organization.

(3) All such notices, other than published notices, shall be given as provided in [section 41-212, Idaho Code](#).

History.

1961, ch. 330, § 52, p. 645; am. 2005, ch. 77, § 3, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-236. Show cause notice. — If any person is entitled to a hearing by any provision of the insurance code before any proposed action is taken, the notice of the proposed action may be in the form of a notice to show cause stating that the proposed action may be taken, unless such person shows cause at a hearing to be held as specified in the notice why the proposed action should not be taken, and stating the basis of the proposed action.

History.

1961, ch. 330, § 53, p. 645.

§ 41-237. Adjourned hearing. — The director may adjourn any hearing from time to time and from place to place without other notice of the adjourned hearing than announcement thereof at the hearing.

History.

1961, ch. 330, § 54, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-238. Nonattendance. — The validity of any hearing held in accordance with the notice thereof shall not be affected by failure of any person to attend or to remain in attendance.

History.

1961, ch. 330, § 55, p. 645.

§ 41-239. Hearing procedure. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 56, p. 645; am. 1990, ch. 283, § 1, p. 793, was repealed by S.L. 2005, ch. 77, § 4.

§ 41-240. Order on hearing. — (1) In the conduct of hearings under this code and making his order thereon, the director shall act in a quasi-judicial capacity.

(2) Within thirty (30) days after termination of a hearing and completion of the transcript, if any, or of any rehearing thereof or reargument thereon, or within such other period as may be specified in this code as to particular proceedings, the director shall make his order on hearing and, subject to subsection (5) below, shall give a copy of the order to each person to whom notice of the hearing was given or required to be given and to any other person who became a party to the hearing by intervention.

(3) The order shall contain a concise statement of the facts as found by the director, and of his conclusions therefrom, and the matters required by section 41-212[, Idaho Code] (orders, notices).

(4) The order may confirm, modify, or nullify action taken under an existing order, or may constitute the taking of any new action coming within the scope of the notice of the hearing.

(5) If notice of the hearing was given by publication as provided for in section 41-235[, Idaho Code], the director may publish the order on hearing once each week for four (4) consecutive weeks in the same newspapers in which such notice was published, the first such publication to be made on the date of the order. Publication of the order shall be in lieu of the giving of copies of the order as required under subsection (2) above. At time of first publication the director shall mail to every advisory organization which has filed with him pursuant to section 41-1425[, Idaho Code], a copy of the published order if the order would affect any interest of members of such advisory organization.

History.

1961, ch. 330, § 57, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in subsections (3) and (5) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-241. Appeals from the director. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 58, p. 645, was repealed by S.L. 1988, ch. 258, § 2. For present comparable provisions, see § 67-5201 et seq.

§ 41-242. Method of appeal. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 59, p. 645; am. 1988, ch. 258, § 1, p. 497; am. 1993, ch. 216, § 30, p. 587, was repealed by S.L. 2005, ch. 77, § 4. For present comparable provisions, see § 67-5201 et seq.

§ 41-243 — 41-245. Record to court — Hearing the appeal — Stay of action on appeal. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised 1961, ch. 330, §§ 60-62, p. 245, were repealed by S.L. 1988, ch. 258, § 2. For present comparable provisions, see § 67-5201 et seq.

§ 41-246. Appeals to Supreme Court. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961 ch. 330, § 63, p. 645, was repealed by S.L. 2005, ch. 77, § 4. For present comparable provisions, see § 67-5201 et seq.

§ 41-247. Inquiry powers of director. — The director shall have power to direct an inquiry in writing to any person subject to his jurisdiction with respect to any insurance transaction or matter relative to a subject of insurance resident, located, or to be performed in this state. The person to whom such an inquiry is addressed shall upon receipt thereof promptly furnish to the director all requested information which is in his possession or subject to his control.

History.

I.C., § 41-247, as added by 1969, ch. 214, § 5, p. 625.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-248. Interstate relations. — If the matter that the director seeks to obtain by request is located outside the state, the person so requested may make it available to the director or his representative to examine the matter at the place where it is located. The director may designate representatives, including officials of the state in which the matter is located, to inspect the matter on his behalf, and he may respond to similar requests from officials of other states.

History.

I.C., § 41-248, as added by 1981, ch. 23, § 1, p. 39.

§ 41-249. Sharing of information among governmental agencies and the national association of insurance commissioners. — (1) Any document, report, or other recorded information provided to the director by any federal, state or foreign regulatory or law enforcement agency, or any combination thereof, or by the national association of insurance commissioners (NAIC), which is marked “confidential” or “for regulator use only” or by similar terms or concerning which the entity requires written assurance that the director maintain such information in confidence before the entity will release the information, may be maintained by the director on a confidential basis and is not required to be disclosed to the public.

(2) The director may provide any document, report, or other recorded information to any federal, state or foreign regulatory or law enforcement agency, or any combination thereof, or to the NAIC, which is marked “confidential” or “for regulator use only” or by similar terms or concerning which the director requires written assurance that the entity maintain such information in confidence before he will release it to such entity.

(3) The director is authorized to enter into agreements with other governments, agencies, or any combination thereof, or with the NAIC, in connection with his duties and responsibilities pursuant to this section.

(4) The application of this section shall not prevent an insurance company or producer or other licensee from obtaining information used by the department of insurance in making regulatory decisions or taking regulatory action affecting the company consistent with chapter 1, title 74, Idaho Code, and title 41, Idaho Code.

History.

I.C., § 41-249, as added by 1994, ch. 309, § 1, p. 976; am. 2003, ch. 102, § 1, p. 322; am. 2007, ch. 281, § 1, p. 812; am. 2015, ch. 141, § 106, p. 379.

STATUTORY NOTES

Prior Laws.

Former § 41-249, which comprised (I.C., § 41-249, as added by 1981, ch. 23, § 1, p. 39), was repealed by S.L. 1982, ch. 120, § 20, effective March 22, 1982.

Amendments.

The 2007 amendment, by ch. 281, in subsections (1) and (2), substituted “federal, state or foreign regulatory or law enforcement agency” for “federal or state government or regulatory or law enforcement agency.”

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in subsection (4).

Compiler’s Notes.

As to national association of insurance commissioners, referred to in subsections (1) and (4), see *<http://naic.org>*.

§ 41-250. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-290 by § 1 of S.L. 1994, ch. 219.

§ 41-251. Civil liability. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised **I.C., § 41-251**, as added by 1981, ch. 23, § 1, p. 39, was repealed by S.L. 1982, ch. 120, § 20, effective March 22, 1982.

§ 41-252. Cooperation between the director of the department of insurance and the director of the department of law enforcement. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, § 41-252, which comprised **I.C., § 41-252**, as added by 1981, ch. 23, § 1, p. 39, was repealed by S.L. 1994, ch. 219, § 2, effective July 1, 1994.

§ 41-253. Statement of purpose — Adoption of international fire code. — (1) The purpose of [sections 41-253 through 41-269, Idaho Code](#), is to protect human life from fire, and to prevent fires. These sections are intended to prescribe regulations consistent with nationally recognized good practice for the safeguarding of life and property from hazards of fire and explosion arising from the storage, handling and use of hazardous substances, materials, and devices, and from conditions hazardous to life or property in the use or occupancy of buildings or premises, and there is hereby adopted the “International Fire Code,” 2000 edition, with appendices thereto, published by the International Code Council, Inc. and such later editions as may be so published and adopted by the state fire marshal, as the minimum standards for the protection of life and property from fire and explosions in the state of Idaho.

(2) A detached single family dwelling, to be constructed upon lands of five (5) acres or more outside an incorporated city and not within a designated area of city impact, shall be exempt from the water supply and access requirements of the adopted version of the International Fire Code unless a county land use or subdivision ordinance requires such compliance. A county adopted ordinance may expand the foregoing exemption applicable to detached single family dwellings by reducing the minimum parcel area requirement after first conducting a public hearing subject to public notice that complies with the requirements set forth in [section 67-6509, Idaho Code](#), and after providing notice by mail to all fire agencies providing services to areas outside an incorporated city and not within a designated area of city impact that might be affected by any such proposal at least twenty-one (21) days prior to such public hearing.

(3) Assistants to the state fire marshal, as provided in [section 41-256, Idaho Code](#), shall apply a reasonable interpretation to the International Fire Code as adopted by the state fire marshal, and rules of the state fire marshal, when undertaking any enforcement action.

(4) For the purposes of [sections 41-253 through 41-269, Idaho Code](#), the “International Fire Code” shall mean the publications as adopted under subsection (1) of this section.

History.

1970, ch. 190, § 1, p. 547; am. and redesign. 1982, ch. 120, § 1, p. 337; am. 2002, ch. 86, § 5, p. 195; am. 2008, ch. 402, § 1, p. 1106; am. 2010, ch. 219, § 1, p. 492.

STATUTORY NOTES**Cross References.**

State fire marshal, § 41-254.

Amendments.

The 2008 amendment, by ch. 402, added subsection (2) and redesignated former subsection (2) as subsection (3).

The 2010 amendment, by ch. 219, added subsection (2) and redesignated the subsequent subsections accordingly.

Compiler's Notes.

This section was formerly compiled as § 39-3501.

The international code council, inc., can be found at <http://www.iccsafe.org>.

See [Idaho Administrative Code § 18.01.50](#) for adoption of the 2015 international fire code.

CASE NOTES**Testimony as to Standards.**

Since the Uniform Fire Code (UFC) is designed to provide “minimum standards for the protection of life and property from fire” and, since the defendant agreed that it would maintain the plaintiff’s property in accordance with those minimum standards, the court did not abuse its discretion in allowing testimony as to the UFC standards. [Empire Lumber Co. v. Thermal-Dynamic Towers, Inc.](#), 132 Idaho 295, 971 P.2d 1119 (1998).

Cited [Jerome Thriftway Drug, Inc. v. Winslow](#), 110 Idaho 615, 717 P.2d 1033 (1986).

§ 41-254. Powers and duties of state fire marshal — International fire code, enforcement and regulations — Reports. — The state fire marshal shall be appointed by the director of the department of insurance, with the approval of the governor and shall serve at the pleasure of the director. The state fire marshal shall have the following powers and duties:

1. To enforce the international fire code.
2. To prescribe regulations in addition to the international fire code as adopted, which may be deemed necessary for the prevention of fires and protection of life and property, and such regulations are to be enforced by the state fire marshal.
3. To make interpretations and rules of the intent of the various provisions of the international fire code as adopted.
4. To adopt, rescind, modify or amend rules and regulations for the exercise of functional powers and duties.
5. To transmit to the governor and legislature, on or before the 15th day of July of every year, a full report of proceedings under [sections 41-253 through 41-269, Idaho Code](#), and such statistics as he may wish to include therein unless some other time for reporting is fixed by law, and such report shall be available to the public.
6. To make recommendations for amendments to the international fire code to be submitted to the promulgating authority for its consideration.
7. To have exclusive jurisdiction over single service integrated fire sprinkler systems. A “single service integrated fire sprinkler system” is defined as an integrated system of underground and overhead piping, valves and sprinklers used exclusively for fire protection purposes and designed in accordance with fire protection engineering standards, including the international fire code, beginning with the first connection to a public water system regardless of the existence or location of a back flow prevention device.
8. No person shall be eligible to serve as state fire marshal unless he:

(a) Has had at least twelve (12) years' full-time paid experience with a state, city or county fire protection agency whose primary function is fire prevention and structural fire safety, including at least five (5) years' experience in an administrative capacity as the chief agency officer; or

(b) Holds a four (4) year college degree in one of the physical sciences and has had at least five (5) years' full-time experience in fire protection and structural fire safety with a fire protection agency; or

(c) Is a member of the American society of fire protection engineers.

History.

1970, ch. 190, § 4, p. 547; am. 1974, ch. 39, § 45, p. 1023; am. and redesign. 1982, ch. 120, § 2, p. 337; am. 1993, ch. 43, § 1, p. 115; am. 1993, ch. 128, § 2, p. 322; am. 2002, ch. 86, § 6, p. 195.

STATUTORY NOTES

Amendments.

This section was amended by two 1993 acts which appear to be compatible and have been compiled together.

The 1993 amendment, by ch. 43, § 1, in subdivision 5. substituted "July" for "February" preceding "of every year,".

The 1993 amendment, by ch. 128, § 2, added present subdivision 7.; and renumbered former subdivision 7. as present subdivision 8.

Compiler's Notes.

This section was formerly compiled as § 39-3504.

The society of fire protection engineers, referred to in paragraph (8)(c), can be found at <http://www.sfpe.org>.

§ 41-255. Duties of state fire marshal. — In addition to the duties prescribed in [section 41-254, Idaho Code](#), the state fire marshal shall:

- (1) Administer and enforce this act.
- (2) Appoint, employ and discharge such deputies and other employees as in his judgment may be necessary, control their powers, prescribe their duties, and fix their compensation.
- (3) Keep books, records and accounts, which shall be open to inspection and audit by the state of Idaho at all times.
- (4) Purchase necessary equipment and supplies, and incur any other reasonable and necessary expense in connection with or required for the purpose of carrying out the provisions of this act.
- (5) Maintain in his office a record of all fires occurring in the state, and of all the facts concerning the same, including statistics as to the extent of such fires and the damage caused thereby and whether such losses were covered by insurance, and if so, in what amount. All such records shall be public, except any testimony taken in an investigation under the provisions of this act which the state fire marshal in his discretion may withhold from the public.
- (6) Establish by rule uniform training provisions for all persons acting as assistants to the state fire marshal as provided in [section 41-256, Idaho Code](#).

History.

1970, ch. 190, § 5, p. 547; am. 1974, ch. 39, § 46, p. 1023; am. and redesign. 1982, ch. 120, § 3, p. 337; am. 2008, ch. 402, § 2, p. 1106.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 402, added subsection (6).

Compiler's Notes.

This section was formerly compiled as § 39-3505.

The words “this act” in subsections (1), (4), and (4) refer to S.L. 1970, Chapter 190, which is presently compiled as §§ 41-253 to 41-266 and 41-269.

§ 41-256. Assistants to state fire marshal — Local appeal procedure.

— (1) The chief of the fire department, or his deputy, of every city or county, or fire protection district organized under state law in which a fire department is established, and in areas where no organized fire department exists the county sheriff, or his deputy, shall be assistants to the state fire marshal in carrying out the provisions of the International Fire Code and rules of the state fire marshal.

(2) Any final decision made by an assistant to the state fire marshal involving an interpretation of the International Fire Code or rules of the state fire marshal shall contain a notification to any party subject to the decision that the decision may be appealed in a local appeal procedure that is substantially similar to the one set forth in the International Fire Code or rules adopted by the state fire marshal.

History.

1970, ch. 190, § 6, p. 547; am. 1974, ch. 39, § 47, p. 1023; am. and redesisg. 1982, ch. 120, § 4, p. 337; am. 1988, ch. 317, § 1, p. 976; am. 2002, ch. 86, § 7, p. 195; am. 2008, ch. 402, § 3, p. 1107.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 402, in the section catchline, added “Local appeal procedure”; added the subsection (1) designation to the existing provisions of the section; in subsection (1), substituted “rules of the state fire marshal” for “such other regulations as set forth by the fire marshal”; and added subsection (2).

Compiler’s Notes.

This section was formerly compiled as § 39-3506.

See [Idaho Administrative Code § 18.01.50](#) for adoption of the 2015 international fire code.

§ 41-257. State fire marshal as chief arson investigation officer. —
The state fire marshal shall be the chief arson investigation officer in the state, and shall have the same responsibility and power in arson investigation as a county sheriff. He shall not, however, interfere at any time in the operation or administration of any fire department or sheriff's office except in matters of fire prevention and arson investigation when requested by the local fire jurisdiction, sheriff's office or written and signed complaint of any person served by the local fire jurisdiction. No person, acting without malice, shall be subject to civil liability for libel or otherwise, by virtue of the filing of complaints, requests, reports or furnishing other information pursuant to this section or required by the director of the department of insurance or the state fire marshal as a result of the authority herein granted.

History.

1970, ch. 190, § 7, p. 547; am. and redesign. 1982, ch. 120, § 5, p. 337.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 39-3507.

§ 41-258. Report of losses by fire insurance companies to state fire marshal. — Every fire insurance company authorized to transact business in this state is hereby required to report to the office of the state fire marshal, within seven (7) days after settlement of all fire losses of one thousand dollars (\$1,000) or more, on property within the state of Idaho and all fire losses resulting in death or personal injury, including those personal injury losses covered by workmen's [worker's] compensation insurance. The report shall state the date of fire, the amount of probable property loss or personal injury, the character of property destroyed or damaged, and supposed cause of the fire. The report shall be in addition to and not in lieu of any report or reports such companies may be required by any law of this state to make to any other state officer.

History.

1970, ch. 190, § 8, p. 547; am. and redesign. 1982, ch. 120, § 6, p. 337.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 39-3508.

The bracketed insertion near the end of the first sentence was added by the compiler to reflect the present statutory language of Title 72, Idaho Code.

§ 41-259. Inspection of buildings — Order of remedy or removal — Service of order. — The state fire marshal, his deputies or assistants, upon the written and signed complaint of any person or whenever he or they shall deem it necessary, may at reasonable hours inspect buildings and premises within their jurisdiction, upon the presentation of proper credentials, except the interior of private dwellings, private garages appertaining to such residences, or buildings on farms of more than five (5) acres.

Whenever any of said officers shall find that any building or other structure which, for want of repairs, or lack of or insufficient fire escapes, automatic or other fire alarm apparatus or fire extinguishing equipment, or by reason of age or dilapidated condition, or due to violation of the International Fire Code or from any other cause, is especially liable to fire, and is so situated as to endanger life, other buildings or structures or said building or structure, he or they shall order the same to be remedied or removed, and such order shall forthwith be complied with by the owner or occupant of such premises or buildings, unless said owner or occupant avail himself of the appeals procedure set forth in this act.

The service of any such order shall be made upon the owner or occupant either by delivering to and leaving with the said person a true copy of the said order, or, by mailing such copy to the owner or occupant's last known address. All mailings shall be registered or certified, with return receipt.

History.

1970, ch. 190, § 9, p. 547; am. and redesign. 1982, ch. 120, § 7, p. 337; am. 2008, ch. 402, § 4, p. 1107.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 402, inserted “due to violation of the International Fire Code” in the second paragraph.

Compiler's Notes.

This section was formerly compiled as § 39-3509.

The words “this act” refer to S.L. 1970, ch. 190, which is compiled as §§ 41-253 to 41-266 and 41-269.

See [Idaho Administrative Code § 18.01.50](#) for adoption of the 2015 international fire code.

CASE NOTES

Scope of Authority.

This section provides a fire district authority to inspect buildings and premises. It only grants authority to a fire district to order remedy and repair of buildings or other structures. A district’s authority to enter repair or removal orders does not extend to all buildings or structures. Instead, such orders may be entered only if some deficiency (want of repairs, or lack of or insufficient fire escapes, automatic or other fire alarm apparatus or fire extinguishing equipment, or by reason of age or dilapidated condition, or due to violation of the International Fire Code) renders the building or structure especially liable to fire. [Schweitzer Basin Water Co. v. Schweitzer Fire Dist.](#), 163 Idaho 186, 408 P.3d 1258 (Ct. App. 2017).

A fire district does not have jurisdiction over the fire hydrants on a private water company’s water system. [Schweitzer Basin Water Co. v. Schweitzer Fire Dist.](#), 163 Idaho 186, 408 P.3d 1258 (Ct. App. 2017).

§ 41-260. Appeal from order of remedy or removal — Appeal from local appeal decision. — If an order to remedy or remove, or a local appeal decision regarding the interpretation of the International Fire Code or rules of the state fire marshal, is made by the deputies or assistants of the state fire marshal, such owner or occupant who receives the order, or a party aggrieved by a local appeal decision, may, within twenty (20) days after receipt of service of such order or local appeal decision, appeal to the state fire marshal, who shall within ten (10) days, review such order or local appeal decision and if affirmed, file his decision thereon, and unless by his authority the order or local appeal decision is revoked or modified it shall remain in full force and be complied with within the time fixed in said order, local appeal decision, or decision of the state fire marshal.

Provided, however, that any such owner, occupant or party who feels himself aggrieved by any such order or local appeal decision, or affirming of such order or local appeal decision, may within thirty (30) days after the making or affirming of any such order or local appeal decision by the state fire marshal, appeal such order or local appeal decision to the district court having jurisdiction of the property.

History.

1970, ch. 190, § 10, p. 547; am. and redesign. 1982, ch. 120, § 8, p. 337; am. 2008, ch. 402, § 5, p. 1107.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 402, rewrote the section to the extent that a detailed comparison is impracticable.

Compiler's Notes.

This section was formerly compiled as § 39-3510.

See [Idaho Administrative Code § 18.01.50](#) for adoption of the 2015 international fire code.

CASE NOTES

Cited Schweitzer Basin Water Co. v. Schweitzer Fire Dist., 163 Idaho 186, 408 P.3d 1258 (Ct. App. 2017).

§ 41-261. Failure to comply with order of remedy or removal — Failure to comply with local decision or local appeal decision — Penalty — Civil action to recover penalty. — Any owner or occupant failing to comply with such order or local decision, or local appeal decision within thirty (30) days after said appeal to the state fire marshal has been determined, or, if no appeal is taken, then within the time fixed in said order, local decision or local appeal decision shall be liable to a penalty of: ten dollars (\$10.00) for each day's neglect beginning with the first day through the seventh day; fifty dollars (\$50.00) per day on the eighth through the thirtieth day; and one hundred dollars (\$100) per day on the thirty-first day and each day thereafter. In the event such enforcement action is brought by the office of the state fire marshal, the penalty shall be payable to the state fire marshal, for deposit in the arson, fire and fraud prevention account. In the event such enforcement action is brought by a fire district under the authority of the state fire marshal, the penalty shall then be payable to the fire district which has prosecuted the enforcement action.

The penalty herein provided, if not then paid, may be recovered in an action brought in any court of competent jurisdiction of the county where such property is located, in the name of the state, under the direction of the state fire marshal and/or any of the assistants herein designated, where such property is located, or by an attorney specially designated therefor by the attorney general, or by the attorney for a fire district in the event such enforcement action is brought by the district. The reasonable attorney's fees and costs incurred in bringing any such enforcement action, if any, shall be awarded to the state or the fire district bringing the enforcement action in addition to the assessment of any penalty, and shall be paid in the same manner as the penalty. If the court determines that the enforcement action has been brought frivolously or without reasonable cause, the court may award to the owner, occupant or party who is the subject of the enforcement action such reasonable attorney's fees and costs of the defense or appeal of the enforcement action as the court determines is fair and just.

History.

1970, ch. 190, § 11, p. 547; am. and redesign. 1982, ch. 120, § 9, p. 337; am. 2004, ch. 266, § 1, p. 748; am. 2008, ch. 402, § 6, p. 1108.

STATUTORY NOTES

Cross References.

Arson, fire and fraud prevention account, § 41-268.

Attorney general, § 67-1401 et seq.

Amendments.

The 2008 amendment, by ch. 402, in the section catchline, inserted “Failure to comply with local decision or local appeal decision”; in the first sentence in the first paragraph, inserted “or local decision, or local appeal decision,” “to the state fire marshal,” and “local decision or local appeal decision”; and in the last sentence in the last paragraph, inserted “or party.”

Compiler’s Notes.

This section was formerly compiled as § 39-3511.

§ 41-262. Failure to comply with order of remedy or removal — Repair or demolition of premises — Expense. — If any person fails to comply with the order of any officer, the state fire marshal or assistants to the state fire marshal under the preceding sections or with the order as modified on appeal as herein provided, and within the time fixed, then such officer, the state fire marshal or assistants to the state fire marshal are hereby empowered and authorized to cause such building or premises to be repaired, torn down or demolished, with the materials removed and all dangerous conditions remedied, at the expense of the person who fails to comply with such order.

History.

1970, ch. 190, § 12, p. 547; am. and redesign. 1982, ch. 120, § 10, p. 337; am. 2008, ch. 402, § 7, p. 1109.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 402, twice inserted “the state fire marshal or assistants to the state fire marshal.”

Compiler’s Notes.

This section was formerly compiled as § 39-3512.

§ 41-263. Failure to pay expense of repair or demolition — Assessment. — If, within thirty (30) days thereafter, such person shall fail, neglect or refuse to repay the expenses for demolishing or repair of said building incurred under the provisions of this act, to the state fire marshal's office if the demolition or repair action was brought by the state fire marshal, or to a fire district if a fire district brought the demolition or repair action, the enforcing officer, state fire marshal or his assistants shall certify such expenses to the clerk of the city, fire district or county in which the property is situated, and the city, fire protection district or county shall certify to the county treasurer the amount of the assessment, which assessment shall be by said county treasurer, placed upon the tax roll and collected as other taxes, and when collected shall be refunded to the state fire marshal for deposit in the arson, fire and fraud prevention account if the demolition or repair action was brought by the state fire marshal, or to a fire district if a fire district brought the demolition or repair action.

History.

1970, ch. 190, § 13, p. 547; am. 1974, ch. 39, § 48, p. 1023; am. and redesisg. 1982, ch. 120, § 11, p. 337; am. 2008, ch. 402, § 8, p. 1109.

STATUTORY NOTES

Cross References.

Arson, fire and fraud prevention account, § 41-268.

Amendments.

The 2008 amendment, by ch. 402, deleted “the marshal” following “to repay,” inserted “to the state fire marshal’s office if the demolition or repair action was brought by the state fire marshal, or to a fire district if a fire district brought the demolition or repair action” and “state fire marshal or his assistants” and added “if the demolition or repair action was brought by the state fire marshal, or to a fire district if a fire district brought the demolition or repair action.”

Compiler’s Notes.

This section was formerly compiled as § 39-3513.

The words “this act” near the beginning of the section refer to S.L. 1970, Chapter 190, which is compiled as §§ 41-253 to 41-266 and 41-269.

§ 41-264. Investigative hearings — Subpoena of witnesses — Conduct of hearing. — The state fire marshal or his deputies shall have the power to request the district court to subpoena witnesses and compel them to attend before them, or either of them, and to testify in relation to any matter which by the provisions of this act is subject to inquiry and investigation, and may require the production of any book, paper or document deemed pertinent or necessary to the inquiry, and shall have the power to administer oaths and affirmations to any person appearing as a witness before them. Any such hearing shall be held in the county where the property is located.

Such examination may be public or private, as the officers conducting the investigation may determine, and persons other than those required to be present may be excluded from the place where such examination is held.

If, after such examination of witnesses or any investigation, the state fire marshal or any of his deputies or assistants is of the opinion that the facts in relation to such fire indicate that a crime has been committed, the state fire marshal or any of his deputies or assistants shall present the testimony taken on such examination, together with any other data in his possession, to the prosecuting attorney of the proper county, with the request that the prosecuting attorney institute such criminal proceedings as such testimony or data may warrant.

History.

1970, ch. 190, § 14, p. 547; am. 1970, ch. 249, § 1, p. 663; am. and redesign. 1982, ch. 120, § 12, p. 337.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 39-3514.

The words “this act” near the middle of the first paragraph refer to S.L. 1970, Chapter 190, which is compiled as §§ 41-253 — 41-266 and 41-269.

§ 41-265. Witness fees — Charge for service of process. — Each person summoned and testifying before the state fire marshal, his deputies or assistants, shall on the certification of the fire marshal and upon audit of the proper officer of the state, receive such sum or sums for witness fees and mileage as are provided for witnesses testifying in the district courts of this state; and officers serving subpoena and rendering other services to the state fire marshal shall be paid in like manner and amounts as they would be entitled for like service in such courts.

History.

1970, ch. 190, § 16, p. 547; am. and redesign. 1982, ch. 120, § 13, p. 337.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 39-3515.

§ 41-266. Admission of international fire code in evidence. — A copy of the international fire code, 2000 edition, or later editions and supplements adopted by the state of Idaho, shall be received in any court in this state as conclusive evidence of the contents of said code.

History.

1970, ch. 190, § 17, p. 547; am. and redesign. 1982, ch. 120, § 14, p. 337; am. 2002, ch. 86, § 8, p. 195.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 39-3516.

See [Idaho Administrative Code § 18.01.50](#) for adoption of the 2015 international fire code.

§ 41-267. Hardship resulting from application of act — Adjustments and variances. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1970, ch. 190, § 18, p. 547; am. and redesign. 1982, ch. 120, § 15, p. 337; am. 1993, ch. 401, § 1, p. 1467, was repealed by S.L. 1998, ch. 247, § 1, effective July 1, 1998.

§ 41-268. Arson, fire and fraud prevention account. — (1) There is hereby created an account in the agency asset fund in the state treasury, to be designated the “arson, fire and fraud prevention account.” The account shall be used by the director of the department of insurance for enforcement of this act, investigation of alleged cases of arson, fraud and related alleged violations of the laws of this state, and prevention of fire, explosions and other conditions necessary for the public safety, health, peace and welfare.

(2) In addition to moneys, if any, appropriated to the account by the legislature, the director shall deposit with the state treasurer for credit to the arson, fire and fraud prevention account:

(a) Penalties collected under the provisions of sections 41-261 and 41-263, Idaho Code;

(b) That portion of the annual continuation fee as determined by the director pursuant to subsection (3) of this section;

(c) Other moneys now or hereinafter in the state fire prevention account;

(d) Other moneys or revenues derived from whatever source for arson or fraud investigation or fire prevention.

(3) A portion of the annual continuation fee, as determined by the director, will be used to fund the arson, fire and fraud [prevention] account.

(4) All claims against the account shall be examined, audited and allowed in the manner now or hereafter provided by law.

(5) All moneys placed in the account are hereby perpetually appropriated to the department of insurance for the purposes of the provisions of this section.

(6) Pending use for purposes of the provisions of this section, moneys in the account shall be invested by the state treasurer in the same manner as provided under [section 67-1210, Idaho Code](#), with respect to other surplus or idle moneys in the state treasury. Interest earned on the investments shall be returned to the account.

History.

I.C., § 41-268, as added by 1982, ch. 120, § 17, p. 337; am. 1983, ch. 135, § 1, p. 331; am. 1999, ch. 65, § 1, p. 168; am. 2001, ch. 85, § 2, p. 211.

STATUTORY NOTES

Cross References.

State treasurer, § 67-1201 et seq.

Compiler's Notes.

The term “this act” in subsection (1) refers to S.L. 1982, ch. 120, which is codified as §§ 41-253 to 41-266, 41-268, 41-269, 41-291, 41-292, and 41-296 to 41-298.

The bracketed insertion in subsection (3) was added by the compiler to correct the name of the referenced account.

§ 41-269. Liberal construction of act. — It is hereby declared that this act is necessary for the public safety, health, peace and welfare, is remedial and preventive in nature, and shall be construed liberally.

History.

1970, ch. 190, § 20, p. 547; am. and redesign. 1982, ch. 120, § 18, p. 337.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 39-3519.

The words “this act” refer to S.L. 1970, Chapter 190, which is compiled as §§ 41-253 to 41-266 and 41-269.

§ 41-270. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-291 by § 3 of S.L. 1994, ch. 219.

§ 41-271. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-292 by § 4 of S.L. 1994, ch. 219.

§ 41-272. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-296 by § 8 of S.L. 1994, ch. 219.

§ 41-273. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-297 by § 9 of S.L. 1994, ch. 219.

§ 41-274. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-298 by § 10 of S.L. 1994, ch. 219.

Idaho Code § 41-275

§ 41-275. [Reserved.]

Idaho Code § 41-276—41-285

§ 41-276 — 41-285. Underground Storage Tank Technician Certification Act. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised, **I.C., §§ 41-276 to 41-285**, as added by 1990, ch. 298, §§ 1 to 10, p. 820; am. 1991, ch. 297, § 1, p. 782; am. 1992, ch. 254, §§ 1, 2, p. 740; am. 1994, ch. 412, § 1, p. 1301, were repealed by S.L. 1997, ch. 93, § 1, effective July 1, 1997.

§ 41-286. Uniform claims processing. — (1) Beginning July 1, 1995, all providers of health insurance coverage in Idaho shall use a uniform claim form/format and uniform billing and claim codes.

(2) The uniform claim form/format and billing codes shall be promulgated by the director as provided in chapter 52, title 67, Idaho Code. The director, when developing the claim form/format and billing codes shall take into consideration forms/formats now in use and shall consult with appropriate federal, state and private organizations.

(3) Beginning July 1, 1996, all insurers shall offer compatible systems of electronic billing approved by the director in accordance with chapter 52, title 67, Idaho Code. The system approved by the director may include monitoring and disseminating information concerning eligibility and coverage of individuals.

History.

I.C., § 41-286, as added by 1994, ch. 98, § 1, p. 223.

STATUTORY NOTES

Compiler's Notes.

Two 1994 acts enacted new sections designated as § 41-286. Section 41-286 as enacted by S.L. 1994, ch. 98, § 1 has been compiled as § 41-286, while the § 41-286 as enacted by S.L. 1994, ch. 322, § 1 has been compiled as § 41-287. The redesignation of the provisions enacted by S.L. 1994, ch. 322 was made permanent by S.L. 2005, ch. 25.

See [Idaho Administrative Code § 18.01.71](#) for rule to adopt uniform health claim form act.

§ 41-287. Application of provisions adopted by national association of insurance commissioners. — The department may not require an insurer to comply with any rule, regulation, directive or standard adopted by the national association of insurance commissioners unless application of the rule, regulation, directive or standard, including policy reserves, is authorized by statute and implemented by the director pursuant to chapter 52, title 67, Idaho Code. This section shall not expand or restrict the general powers and authority of the director as set forth in [section 41-210, Idaho Code](#).

History.

[I.C., § 41-286](#), as added by 1994, ch. 322, § 1, p. 1027; am. and redesign. 2005, ch. 25, § 95, p. 82.

STATUTORY NOTES

Compiler's Notes.

Two 1994 acts enacted new sections designated as § 41-286. Section 41-286 as enacted by S.L. 1994, ch. 98, § 1 has been compiled as § 41-286, while the § 41-286 as enacted by S.L. 1994, ch. 322, § 1 has been compiled as § 41-287. The redesignation of the provisions enacted by S.L. 1994, ch. 322 was made permanent by S.L. 2005, ch. 25.

As to national association of insurance commissioners, referred to in this section, see <http://naic.org>.

§ 41-288. Retaliatory requirement. — Should an insurance department, commissioner, director, or other similar insurance regulatory official of any other state or territory of the United States, impose any sanctions, fines, penalties, financial or deposit requirements, prohibitions, restrictions, regulatory requirements, or other obligations, of any kind, upon any insurance company organized or chartered in this state and licensed to transact business in such other state or territory, because of the failure of the Idaho department of insurance to obtain, maintain, or receive accreditation, certification, or any similar form of approval, compliance, or acceptance from, by, or as a member of the national association of insurance commissioners, or any committee, task force, working group, or advisory committee thereof, or because of the failure of the Idaho department of insurance to comply with any directive, financial or annual statement requirement, model act or regulation, market conduct or financial examination report or requirement, or any report of any kind of the national association of insurance commissioners, or any committee, task force, working group, or advisory committee thereof, the director shall, without exception or exclusion, impose upon any and all insurance companies organized or chartered in such other state or territory, and licensed to do business in this state, the same sanctions, fines, penalties, financial or deposit requirements, prohibitions, restrictions, regulatory requirements, or other obligations imposed by such state upon the insurance company domiciled in this state.

History.

I.C., § 41-288, as added by 1995, ch. 138, § 1, p. 592.

STATUTORY NOTES

Compiler's Notes.

As to national association of insurance commissioners, referred to in this section, see <http://naic.org>.

§ 41-290. Fraudulent claims. — Any insurer which has facts to support a belief that a fraudulent claim is being or has been made shall, within sixty (60) days of the receipt of such notice, send to the director of insurance, on a form prescribed by the director, the information requested and such additional information relative to the claim and the parties claiming loss or damages as the director may require. The director of the department of insurance shall review such reports and select such claims as, in his judgment, may require further investigation. He shall then cause an independent examination of the facts surrounding such claim to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the claim. The director of the department of insurance shall report any alleged violations of law which his investigations disclose to the appropriate licensing agency and prosecuting authority having jurisdiction with respect to any such violation.

If, upon examination, the director of the department of insurance determines that an insurer has intentionally not reported a claim when the insurer had facts to support a belief that the claim was fraudulent in accordance with the provisions of this chapter, the director may impose fines and penalties pursuant to [section 41-327, Idaho Code](#), for each unreported suspected fraudulent claim.

History.

[I.C., § 41-250](#), as added by 1981, ch. 23, § 1, p. 39; am. and redesign. 1994, ch. 219, § 1, p. 696.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-250.

§ 41-291. Definitions. — As used in sections 41-290 through and including 41-298, Idaho Code:

(1) Sections 41-290 through 41-298, Idaho Code, shall be known as the “Idaho Arson and Fraud Reporting-Immunity Act.”

(2) “Authorized agencies” shall mean:

(a) Any law enforcement agency of this state;

(b) Any prosecuting attorney who may be responsible for prosecution in the jurisdiction where the fire or fraud occurred;

(c) The attorney responsible for the prosecution in the jurisdiction where the fire or fraud occurred as designated by the attorney general;

(d) The department of insurance, which includes the state fire marshal.

(3) Solely for the purpose of section 41-292(1), Idaho Code, “authorized agencies [agency]” shall also include:

(a) The United States attorney’s office when authorized or charged with investigation or prosecution of the fire or fraud in question;

(b) The federal bureau of investigation or any other federal agency, charged with investigation or prosecution of the fire or fraud in question.

(4) “Relevant” means information having any tendency to make the existence of any fact that is of consequence to the investigation or determination of the issue more probable or less probable than it would be without the evidence.

(5) Material will be “deemed important,” if within the sole discretion of the “authorized agency,” such material is requested by the “authorized agency.”

(6) “Action,” as used in this chapter, shall include nonaction or the failure to take action.

(7) “Immunity” means that no civil action may arise against any person for furnishing information pursuant to section 41-248, 41-258, 41-290, 41-292, 41-296 or 41-297, Idaho Code, where actual malice on the part of the

insurance company, department of insurance, state fire marshal, authorized agency, their employees or agents, is not present.

(8) “Financial loss” includes, but is not limited to, loss of earnings, out-of-pocket and other expenses, repair and replacement costs and claims payments.

(9) “Person” means a natural person, company, corporation, unincorporated association, partnership, professional corporation and any other legal entity.

(10) “Practitioner” means a licensee of this state authorized to practice medicine and surgery, psychology, chiropractic, law or any other licensee of the state whose services are compensated, directly or indirectly, by insurance proceeds, or a licensee similarly licensed in other states and nations or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

(11) “Statement” includes, but is not limited to, any of the following regardless of how it is made and in what format it is contained:

- (a) Information submitted on an application for insurance;
- (b) Description of policy terms, conditions, benefits or illustrations;
- (c) Proof of insurance, certificate of insurance, or insurance card;
- (d) Proof of claim, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical records, X-rays, test results or other evidence of loss, injury or expense; and
- (e) Any other notice, correspondence, representation or information relating to an insurance coverage or claim.

(12) “Insurer” shall mean any insurance company contemplated by title 41, Idaho Code, any business operating as a self-insured for any purpose, the state insurance fund, and any self-insured as contemplated by title 72, Idaho Code.

(13) “Runner” means a person who procures, or persons working in conjunction with each other who procure, clients at the direction of, or in cooperation with, a person who, with the intent to deceive or defraud,

performs or obtains a service or benefit under a contract of insurance or asserts a claim against an insured.

History.

I.C., § 41-270, as added by 1982, ch. 120, § 19, p. 337; am. and redesign. 1994, ch. 219, § 3, p. 696; am. 1997, ch. 122, § 1, p. 367; am. 1998, ch. 428, § 5, p. 1346; am. 2000, ch. 469, § 104, p. 1450; am. 2005, ch. 74, § 1, p. 251; am. 2007, ch. 239, § 1, p. 707.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

State fire marshal, § 41-254.

State insurance fund, § 72-901 et seq.

Amendments.

The 2007 amendment, by ch. 239, rewrote subsection (11), which formerly read: “Statement’ includes, but is not limited to, any notice statement, any statement submitted on applications for insurance, proof of claim, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bills for services, diagnosis, prescription, hospital or doctor records, X-rays, test results or other evidence of loss, injury or expense, whether oral, written or computer generated”; and added subsection (13).

Compiler’s Notes.

This section was formerly compiled as § 41-270.

The bracketed insertion in subsection (3) was added by the compiler to supply the correct defined term.

Effective Dates.

Section 11 of S.L. 1998, ch. 428 declared an emergency and provided the act shall be in full force and effect on and after its passage and approval. Approved April 3, 1998.

§ 41-292. Disclosure of information by insurers. — (1) The director of the department of insurance, state fire marshal or any authorized agency may, in writing, require the insurance company at interest to release to the requesting agency any or all relevant information or evidence deemed important to the authorized agency, director or state fire marshal which the company may have in its possession, relating to the loss in question. Relevant information may include, without limitation herein:

- (a) Pertinent insurance policy information relevant to a loss under investigation and any application for such a policy;
- (b) Policy premium payment records which are available;
- (c) History of previous claims made by the insured;
- (d) Material relating to the investigation of the loss, including statements of any person, proof of loss, and any other evidence relevant to the investigation.

(2)(a) When an insurance company has facts to support a belief that a loss in which it has an interest may be of other than accidental cause, then, for the purpose of notification and for having such loss investigated, the company shall, in writing, notify the director of the department of insurance, or the state fire marshal, and provide any or all material developed from the company's inquiry into the loss.

(b) When an insurance company provides the director of the department of insurance or the state fire marshal with notice of a loss, it shall be sufficient notice for the purpose of this chapter.

(c) Nothing in [section 41-292\(1\), Idaho Code](#), shall abrogate or impair the rights or powers created under [section 41-292\(2\), Idaho Code](#).

(3) The director of the department of insurance, the state fire marshal or an authorized agency provided with information pursuant to section 41-248, 41-258, 41-290 or 41-292(1) or (2), Idaho Code, and in furtherance of its own purposes, may release or provide such information to any of the other authorized agencies.

(4) Any insurance company providing information to an authorized agency or agencies pursuant to section 41-258, 41-290 or 41-292(1) or (2), Idaho Code, shall have the right to request relevant information relative to the loss in question and to receive, within a reasonable time, not to exceed thirty (30) days, the information requested, if the information is not otherwise privileged by law.

(5) In the absence of fraud or malice, no person shall be subject to civil liability for libel, slander or any other relevant tort cause of action by virtue of filing reports or furnishing other information required by this chapter or required by the director of the department of insurance under the authority granted in this chapter, and no civil cause of action of any nature shall arise against such person:

(a) For any information relating to suspected fraudulent insurance acts furnished to or received from authorized agencies, their agents and employees; or

(b) For any information relating to suspected fraudulent insurance acts furnished to or received from other persons subject to the provisions of this chapter; or

(c) For any such information furnished in reports to the department of insurance, national association of insurance commissioners, national insurance crime bureau or any organization established to detect and prevent fraudulent insurance acts, their agents, employees or designees, nor shall the director or any employee of the department of insurance, acting without malice in the absence of fraud, be subject to civil liability for libel, slander or any other relevant tort and no civil cause of action of any nature shall arise against such person by virtue of the publication of any report or bulletin related to the official activities of the department of insurance. Nothing herein is intended to abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

(6) For purposes of subsection (5) of this section, there shall exist a rebuttable presumption that the person has acted without fraud or malice.

History.

I.C., § 41-271, as added by 1982, ch. 120, § 19, p. 337; am. and redesign. 1994, ch. 219, § 4, p. 696; am. 2005, ch. 74, § 2, p. 251.

STATUTORY NOTES

Cross References.

State fire marshal, § 41-254.

Compiler's Notes.

This section was formerly compiled as § 41-271.

As to national association of insurance commissioners, referred to in paragraph (5)(c), see <http://naic.org>.

The national insurance crime bureau, referred to in paragraph (5)(c), is a not-for-profit organization dedicated to fighting insurance fraud and crime. See <https://www.nicb.org/>.

§ 41-293. Insurance fraud. — Insurance fraud includes:

(1)(a) Any person who, with the intent to defraud or deceive an insurer for the purpose of obtaining any money or benefit, presents or causes to be presented to any insurer, producer, practitioner or other person, any statement as part of, or in support of, a claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim; or

(b) Any person who, with intent to defraud or deceive an insurer assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to any insurer, producer, practitioner or other person, in connection with, or in support of, any claim for payment or other benefit, knowing that such statement contains false, incomplete, or misleading information concerning any fact or thing material to such claim;

(c) Any person who, with intent to defraud or deceive, presents or causes to be presented to or by an insurer, a producer, practitioner or other person, a false or altered statement material to an insurance transaction;

(d) Any insurance producer or other person who, with intent to defraud or deceive, willfully takes premium money knowing that insurance coverage will not be effected;

(e) Any practitioner or other person who willfully submits a false or altered statement, with the intent of deceiving an insurer or other person in connection with an insurance transaction or claim;

(f) Anyone willfully making a false statement or material misrepresentation to an insurer, employer, practitioner or other person, with the intent to defraud or deceive an insurer or other person, to obtain or extend worker's compensation benefits;

(g) Anyone who offers or accepts a direct or indirect inducement to file or solicits another person to file a false statement, with intent to defraud or deceive an insurer;

(h) Any person who, with intent to defraud or deceive, transacts insurance of any kind or character, or transmits for a person other than himself an application for a policy of insurance, without proper licensing or after such license has been suspended or revoked;

(i) Any practitioner or any other person who, with intent to defraud or deceive, employs, uses or acts as a runner for the purpose of submitting a claim containing false, incomplete, or misleading information concerning any fact or thing material to such claim;

(j) Any employer or other person who, with intent to defraud or deceive, presents or causes to be presented to an insurer, producer or any other person or governmental agency any statement containing the number of employees, amount of payroll, job description or job title or any other statement material to worker's compensation insurance which contains false, misleading or incomplete information; or

(k) Any person who, with intent to defraud or deceive, obstructs the director in the conduct of any authorized examination.

(2) A fact, statement or representation is "material" if it includes any of the following:

(a) Any fact which, if communicated to the producer, insurer, adjuster or representative thereof, would induce him to either decline insurance altogether or not accept it unless a higher premium is paid by the insured;

(b) Any fact relating to a claim for insurance benefits which, if disclosed, would be a fair reason for rejecting a claim for insurance benefits;

(c) Any fact, the knowledge or ignorance of which would naturally influence the insurer in making or refusing the contract, in estimating the degree or character of the risk, or in fixing the rate of premium;

(d) Any fact, the knowledge or ignorance of which would naturally influence the insurer in accepting or rejecting a claim for insurance benefits or compensation, or in determining the amount of compensation or insurance benefits to be paid to the insured; or

(e) Any fact that necessarily has some bearing on the subject matter of the insurance coverage or claim for benefits under an insurance contract.

(3) Any offense committed by use of a telephone, any means of electronic communication or mail as provided by this chapter may be deemed to have been committed at the place from which the telephone call or electronic communication was made, or mail was sent, or the offense may be deemed to have been committed at the place at which the telephone call, electronic communication or mail was received.

(4) Any violator of this section is guilty of a felony and shall be subject to a term of imprisonment not to exceed fifteen (15) years, or a fine not to exceed fifteen thousand dollars (\$15,000), or both and shall be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of a violation of this section. Each instance of violation may be considered a separate offense.

History.

I.C., § 41-1325, as added by 1981, ch. 23, § 3, p. 39; am. and redesign. 1994, ch. 219, § 5, p. 696; am. 1997, ch. 122, § 2, p. 367; am. 2007, ch. 239, § 2, p. 707.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 239, throughout subsection (1), substituted “producer, practitioner or other person” for “a purported insurer, broker or agent”; in subsections (1)(a) and (1)(b), deleted “written or oral” preceding the first occurrence of “statement”; in subsection (1)(a), deleted “including computer generated documents” following the first occurrence of “statement”; in subsection (1)(c), deleted “insurance agent or other” following “Any,” “an insurer” following “deceive,” and “materially” preceding “false,” and substituted “statement material to an insurance transaction” for “application of insurance”; in subsection (1)(d), substituted “producer” for “agent,” and inserted the last occurrence of “insurance”; in subsection (1)(e), deleted “medical” preceding “practitioner,” inserted “or other person,” substituted “statement” for “bill,” and added “or other person in connection with an insurance transaction or claim”; in subsection (1)(f), inserted “to an insurer, employer, practitioner or other person” and “or other person,” and substituted “intent to defraud or deceive” for “intent of deceiving”; in subsection (1)(g), inserted “or solicits another person to file,”

deleted “of claim” following “statement,” and substituted “intent to defraud or deceive” for “intent of deceiving”; and added subsections (1)(h) through (1)(k) and (2), and redesignated subsections accordingly.

Compiler’s Notes.

This section was formerly compiled as § 41-1325.

CASE NOTES

Double jeopardy.

Materiality.

Sufficiency of evidence.

Double Jeopardy.

The reimbursement requirements of § 72-801 are in the nature of a civil forfeiture. Reimbursement under § 72-801 clearly bears a legitimate remedial purpose: the repayment of money to which the employee was never entitled. In addition, reimbursement bears a rational relationship to that purpose. Thus, the imposition of a criminal punishment under this section and reimbursement under § 72-801 does not constitute double jeopardy in violation of the [United States Constitution’s Double Jeopardy Clause](#), or the [Idaho Constitution](#). [Berglund v. Potlatch Corp.](#), 129 Idaho 752, 932 P.2d 875 (1996).

Materiality.

On a charge of felony insurance fraud for making a false statement, materiality is not an element; therefore, a district court properly convicted defendant, a worker’s compensation recipient, of felony insurance fraud because of a false statement made during a deposition regarding defendant’s participation in a painting business. [State v. Maynard](#), 139 Idaho 117, 73 P.3d 731 (Ct. App. 2003).

Sufficiency of Evidence.

The evidence was held sufficient to support verdicts against the defendants for filing false information in support of insurance claim, where the insurance investigator, who was experienced in assessing the value of second-hand goods, testified that the value of the goods in the mobile home

which had suffered a fire was, at the maximum, \$1000, and that they were not worth the \$20,000 sought by defendants in their insurance claim. *State v. Jussaume*, 112 Idaho 108, 730 P.2d 1028 (Ct. App. 1986).

An accomplice's testimony linking defendant to a fire which destroyed his own house was sufficiently corroborated by evidence that defendant moved almost all of his uninsured equipment out of the house just before the fire, that defendant called the fire department from neighbor's house instead of his own, that defendant made an appointment prior to the fire to get a new artificial leg, that defendant left his wallet and checkbook in pickup taken by his accomplice, that defendant listed an inflated value for his house on his proof of loss form, that defendant had access to the two points of origin of the fire which expert testified were started by accelerants, that he had opportunity to set the fire in those areas, and that defendant would gain substantially if his inflated proof of loss was paid. *State v. Morris*, 116 Idaho 16, 773 P.2d 284 (Ct. App. 1989).

Defendant intentionally attempted to hide the loss history associated with involving a prospective insured by submitting an insurance application in a false name and failing to disclose all parties that were seeking insurance; therefore, those misrepresentations amounted to a violation of paragraph (1) (c) of this section, resulting in substantial and competent evidence that defendant committed insurance fraud. *State v. Hoyle*, 140 Idaho 679, 99 P.3d 1069 (2004).

Decisions Under Prior Law

Intent to Deceive.

Incorrect statement by insured of his interest and interest of others in insured property did not prevent recovery in absence of intent to deceive, although policy provided that it should be void in case of fraud or false statement by insured. *Alliance Ins. Co. v. Enders*, 293 F. 485 (9th Cir. 1923).

§ 41-294. Damage to or destruction of insured property. — Any person who wilfully burns or in any other manner injures or destroys any property which is at the time insured against loss or damage, with intent to defraud or prejudice the insurer or for personal gain, whether the same be the property of, or in possession of, such person or any other, is guilty of a felony punishable by imprisonment in the state prison not less than one (1) year nor more than fifteen (15) years, and shall be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of a violation of this section.

History.

1961, ch. 330, § 304, p. 645; am. and redesign. 1994, ch. 219, § 6, p. 696; am. 1997, ch. 122, § 3, p. 367.

STATUTORY NOTES

Cross References.

Arson, § 18-801 et seq.

Compiler's Notes.

This section was formerly compiled as § 41-1326.

CASE NOTES

Sufficiency of Evidence.

An accomplice's testimony linking defendant to a fire which destroyed his own house was sufficiently corroborated by evidence that defendant moved almost all of his uninsured equipment out of the house just before the fire, that defendant called the fire department from neighbor's house instead of his own, that defendant made an appointment prior to the fire to get a new artificial leg, that defendant left his wallet and checkbook in pickup taken by his accomplice, that defendant listed an inflated value for his house on his proof of loss form, that defendant had access to the two points of origin of the fire which expert testified were started by accelerants, that he had opportunity to set the fire in those areas, and that defendant

would gain substantially if his inflated proof of loss was paid. *State v. Morris*, 116 Idaho 16, 773 P.2d 284 (Ct. App. 1989).

Cited *State v. Currington*, 113 Idaho 538, 746 P.2d 997 (Ct. App. 1987); *State v. Rodriguez*, 118 Idaho 957, 801 P.2d 1308 (Ct. App. 1990).

RESEARCH REFERENCES

ALR. — What constitutes contamination within policy clause excluding coverage. 72 A.L.R.4th 633.

§ 41-295. Duties of the investigation section. — The investigation section of the department of insurance shall have the following duties:

(1) To conduct civil or criminal investigations within or outside this state as deemed necessary to determine whether any person has violated any provision of title 41, Idaho Code.

(2) For purposes of any investigation under this code, the director, or any officer designated by him, may administer oaths and affirmations, subpoena bank records, subpoena witnesses and compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents the director deems relevant or material to the investigation.

(3) The investigation section shall furnish all papers, documents, reports, complaints, or other facts of evidence to any police, sheriff or other law enforcement agency, when so requested, and will assist and cooperate with such law enforcement agencies.

(4) The investigation section shall refer criminal violations of the code to the attorney general, county prosecutor, or other prosecutor having jurisdiction of any such violation. The attorney general, county prosecutor, or other prosecutor shall promptly institute and prosecute such action or proceedings against such person as the information may require or justify. Whoever is the prosecuting attorney of record shall have exclusive authority in all matters regarding such action or proceeding.

(5) The investigation section shall have such other duties as the director of the department of insurance shall assign or as contained elsewhere in title 41, Idaho Code.

(6) The investigation section shall be permitted to seek court ordered restitution as reimbursement, for the cost of investigation from those individuals successfully prosecuted under [section 41-293, Idaho Code](#). Any restitution payments received pursuant to this section shall be deposited in the insurance administrative account as provided in [section 41-401, Idaho Code](#).

History.

I.C., § 41-295, as added by 1994, ch. 219, § 7, p. 696; am. 1997, ch. 122, § 4, p. 367; am. 2005, ch. 74, § 3, p. 251.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Effective Dates.

Section 5 of S.L. 1997, ch. 122 declared an emergency. Approved March 17, 1997.

§ 41-296. Confidentiality — Compulsory testimony. — (1) The department of insurance, state fire marshal or authorized agency described in [section 41-291, Idaho Code](#), which has received any information furnished pursuant to section 41-258, 41-290 or 41-292, Idaho Code, shall hold the information and the information shall be subject to disclosure according to chapter 1, title 74, Idaho Code.

(2) Any authorized agency referred to in [section 41-291, Idaho Code](#), or their personnel, may be required to testify in any litigation in which the insurance company at interest is named as a party, if such testimony is not otherwise privileged by law.

History.

[I.C., § 41-272](#), as added by 1982, ch. 120, § 19, p. 337; am. 1990, ch. 213, § 53, p. 480; am. and redesign. 1994, ch. 219, § 8, p. 696; am. 2015, ch. 141, § 107, p. 379.

STATUTORY NOTES

Cross References.

State fire marshal, § 41-254.

Amendments.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in subsection (1).

Compiler’s Notes.

This section was formerly compiled as § 41-272.

Effective Dates.

Section 111 of S.L. 1990, ch. 213 as amended by § 16 of S.L. 1991, ch. 329 provided that §§ 3 through 45 and 48 through 110 of the act should take effect July 1, 1993.

§ 41-297. Disclosure requirements. — (1) No person or agency shall intentionally or knowingly refuse to release any information requested pursuant to section 41-292(1) or (3), Idaho Code.

(2) No person shall intentionally or knowingly refuse to provide authorized agencies relevant information pursuant to [section 41-292\(2\)](#), [Idaho Code](#).

(3) No person shall fail to hold in confidence information required to be held in confidence by [section 41-296](#), [Idaho Code](#).

(4) Whoever violates subsection (1), (2) or (3) of this section, is guilty of a misdemeanor, and upon conviction, shall be punished by a fine not to exceed one thousand dollars (\$1,000). In addition to any criminal penalty, if the person is an insurance company or other person licensed by or regulated by the director of insurance, the director may, after hearing thereon, impose an administrative penalty on the violator not to exceed five thousand dollars (\$5,000).

History.

[I.C., § 41-273](#), as added by 1982, ch. 120, § 19, p. 337; am. and redesign. 1994, ch. 219, § 9, p. 696.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-273.

§ 41-298. Jurisdiction — Construction of provisions. — (1) The provisions of this chapter shall not be construed to affect or repeal any ordinance of any municipality relating to fire prevention or the control of arson or fraud, but the jurisdiction of the state fire marshal, the director, department of insurance, and the director, Idaho state police, in such municipality is to be concurrent with that of the municipal and county authorities.

(2) With the exception of [section 41-291\(7\), Idaho Code](#), all other provisions of this chapter shall not be construed to impair any existing statutory or common law rights or powers.

History.

[I.C., § 41-274](#), as added by 1982, ch. 120, § 19, p. 337; am. and redesign. 1994, ch. 219, § 10, p. 696; am. 2000, ch. 469, § 105, p. 1450.

STATUTORY NOTES

Cross References.

Director of state police, § 67-2901 et seq.

State fire marshal, § 41-254.

Compiler's Notes.

This section was formerly compiled as § 41-274.

Effective Dates.

Section 21 of S.L. 1982, ch. 120 declared an emergency. Approved March 22, 1982.

Chapter 3

AUTHORIZATION OF INSURERS AND GENERAL REQUIREMENTS

Sec.

41-301. “Stock” insurer defined.

41-302. “Mutual” insurer defined.

41-302A. “Deposit guarantee” corporation defined.

41-303. “Reciprocal” insurer defined.

41-304. “Charter” defined.

41-305. Certificate of authority required.

41-306. Exceptions to certificate of authority requirement.

41-306A. Interstate insurance sales.

41-307. Authorization for investment purposes only.

41-308. General eligibility for certificate of authority.

41-309. Government-owned insurers not to be authorized.

41-310. Payment of back taxes.

41-311. Name of insurer.

41-312. Combinations of insuring powers — One insurer.

41-313. Capital funds required — Foreign insurers and new domestic insurers.

41-313A. Domestic reciprocal insurers with fewer than seven subscribers.

41-314. Capital funds required — Old domestic insurers. [Repealed.]

41-315. Permissible insuring combinations without additional capital funds.

41-316. Deposit — Foreign or alien insurers.

41-316A. Deposit — General requirement — Domestic insurers.

41-317. Special deposit — Workmen's compensation insurers. [Repealed.]

41-318. Cooperation with the department of health and welfare.

41-319. Application for certificate of authority.

41-320. Consideration of application.

41-321. Filing of articles of incorporation. [Repealed.]

41-322. Issuance or refusal of certificate of authority.

41-322A. Certificates of authority for deposit guarantee corporations.

41-323. What certificate evidences — Ownership of certificate.

41-324. Continuance, expiration, or reinstatement of certificate of authority.

41-325. Amendment of certificate of authority.

41-326. Suspension or revocation of certificate of authority — Mandatory grounds.

41-327. Administrative penalty — Suspension or revocation of certificate of authority — Discretionary and special grounds.

41-328. Order and notice of suspension, revocation or refusal — Effect upon agents' authority.

41-329. Duration of suspension — Insurer's obligations during suspension period — Reinstatement.

41-330. Impaired insurers — Notice to agents — Penalty.

41-331. Impaired insurers — Liability of officers.

41-332. Foreign insurers exempt from corporation laws governing admission of foreign corporations.

41-333. Director as process agent for foreign insurers and domestic reciprocal insurers.

41-334. Serving process — Time to plead.

41-335. Annual statement.

41-336. Review of annual statement — Additional information.

41-336A — 41-336D. Statistical reports — Disposition — Penalties — Fees.[Repealed.]

41-337. Resident agent, countersignature law.

41-338. Exceptions to resident agent, countersignature law.

41-339. Affidavit of compliance with resident agent, countersignature law.
[Repealed.]

41-340. Retaliatory provision.

41-341. Operational standards between insurer, its parent corporation, subsidiary or affiliated person.

41-342. Redomestication as a domestic insurer — Conversion to foreign insurer.

41-343. Articles of redomestication.

41-344. Effective date of redomestication.

41-345. Report.

41-346. Acquisitions and dispositions of assets.

41-347. Nonrenewals, cancellations or revisions of ceded reinsurance agreements.

41-348. Prohibited acts — Service providers.

41-349. Pharmacy benefit managers.

§ 41-301. “Stock” insurer defined. — For the purposes of this code a “stock” insurer is an incorporated insurer with its capital divided into shares and owned by its stockholders.

History.

1961, ch. 330, § 64, p. 645.

§ 41-302. “Mutual” insurer defined. — A “mutual” insurer is an incorporated insurer without capital stock and the governing body of which is elected by its policy holders. This definition shall not be deemed to exclude as “mutual” insurers certain foreign insurers found by the director to be organized on the mutual plan under the laws of their states of domicile, but having temporary share capital or providing for election of the insurer’s governing body on a reasonable basis by policy holders and others.

History.

1961, ch. 330, § 65, p. 645.

STATUTORY NOTES

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

State Insurance Fund.

Although there are certain similarities between the state insurance fund and mutual insurance carriers, the differences in the management schemes of the two entities are far more significant. *Kelso & Irwin, P.A. v. State Ins. Fund*, 134 Idaho 130, 997 P.2d 591 (2000).

§ 41-302A. “Deposit guarantee” corporation defined. — A deposit guarantee corporation is an incorporated insurer without capital stock, the members of which are policy holders and the governing body of which is elected by its members.

History.

I.C., § 41-302A, as added by 1983, ch. 177, § 1, p. 484.

§ 41-303. “Reciprocal” insurer defined. — A “reciprocal” insurer is as defined in section 41-2902[, Idaho Code].

History.

1961, ch. 330, § 66, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertion was added by the compiler to conform to the statutory citation style.

§ 41-304. “Charter” defined. — “Charter” means articles of incorporation, articles of agreement, articles of association or other basic constituent document of a corporation, or the power of attorney of a reciprocal insurer.

History.

1961, ch. 330, § 67, p. 645.

§ 41-305. Certificate of authority required. — (1) No person shall act as an insurer and no insurer or its agents, attorneys, subscribers, or representatives shall directly or indirectly transact insurance in this state except as authorized by a subsisting certificate of authority issued to the insurer by the director, except as to such transactions as are expressly otherwise provided for in this code.

(2) No insurer shall from offices or by personnel or facilities located in this state solicit insurance applications or otherwise transact insurance in another state or country unless it holds a subsisting certificate of authority issued to it by the director authorizing it to transact the same kind or kinds of insurance in this state.

History.

1961, ch. 330, § 69, p. 645.

STATUTORY NOTES

Cross References.

Application for certificate of authority, § 41-319.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

[Insurer strictly accountable.](#)

[Insurer without a certificate.](#)

[Insurer Strictly Accountable.](#)

Where insurance company was found to have committed acts specifically defined as acts for which an insurer is held strictly accountable, although the violation of this section and §§ 41-1030 and 41-1063 (now repealed) arguably resulted from the agents' submission of a false application,

insurance company nonetheless was responsible under these sections and was subject to sanctions by the director of the department of insurance. [Pan Am. Assurance Co. v. Department of Ins.](#), 121 Idaho 884, 828 P.2d 913 (Ct. App. 1992).

Insurer Without a Certificate.

The director of the department of insurance determined that (1) through its agents insurance company had solicited insurance in Idaho, in violation of § 41-1030; (2) by its acceptance of customer's application and its issuance of an insurance policy to her, insurance company had transacted insurance in Idaho without a certificate of authority, in violation of this section; and (3) insurance company had paid a sales commission to agents who were not authorized to make that sale of insurance, in violation of § 41-1063(1) (now repealed); pursuant to the authority granted in § 41-327, the director assessed an administrative penalty against insurance company in the amount of \$1,000 which penalty was found to be reasonable. [Pan Am. Assurance Co. v. Department of Ins.](#), 121 Idaho 884, 828 P.2d 913 (Ct. App. 1992).

Employment service provider that offered a variety of services to small businesses, including insurance services, was a multiple employer welfare arrangement (MEWA), as defined by [29 U.S.C.S. § 1002\(40\)](#), because it offered health benefits to two or more employers; thus, it violated the Idaho Code by transacting the business of insurance without a certificate of authority. Idaho department of insurance had the authority to enforce the provisions of the Idaho Code and to regulate and investigate insurance matters, and nothing precluded that grant of authority from extending to MEWAs. [Emplrs Res. Mgmt. Co. v. Dep't of Ins.](#), 143 Idaho 179, 141 P.3d 1048 (2006), overruled on other grounds, [Verska v. St. Alphonsus Med. Ctr.](#), 151 Idaho 889, 265 P.3d 502 (2011).

Decisions Under Prior Law Police Power.

Public interest is so affected by insurance business carried on in state that private right of contract in connection therewith may be subjected to the police power. [Intermountain Lloyds v. Diefendorf](#), 51 Idaho 304, 5 P.2d 730 (1931).

§ 41-306. Exceptions to certificate of authority requirement. — A certificate of authority and application therefor pursuant to [section 41-319, Idaho Code](#), shall not be required of an insurer with respect to the following:

(1) Investigation, settlement, or litigation of claims under its policies lawfully written in this state, or liquidation of assets and liabilities of the insurer (other than collection of new premiums), all as resulting from its former authorized operations in this state.

(2) Transactions thereunder subsequent to issuance of a policy covering only subjects of insurance not resident, located or expressly to be performed in this state at time of issuance, and lawfully solicited, written and delivered outside this state.

(3) Transactions pursuant to surplus lines coverages lawfully written under chapter 12, title 41, Idaho Code.

(4) Reinsurance, when transacted by an insurer duly authorized by its state of domicile to transact the kind of insurance involved.

(5) The continuation and servicing of life insurance or disability insurance policies or annuity contracts remaining in force as to residents of this state if the insurer has withdrawn from the state and is not transacting new insurance therein.

(6) A foreign insurer licensed and authorized to sell individual or group accident and sickness insurance in another state as defined pursuant to [section 41-306A, Idaho Code](#), and the insurer obtains a certificate of authority pursuant to that section.

History.

1961, ch. 330, § 69, p. 645; am. 2018, ch. 166, § 1, p. 339.

STATUTORY NOTES

Amendments.

The 2018 amendment, by ch. 166, inserted “and application therefor pursuant to **section 41-319, Idaho Code**” in the introductory paragraph; substituted “chapter 12, title 41, Idaho Code” for “chapter 12 of this code” at the end of subsection (3); and added subsection (6).

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

S.L. 2018, ch. 166, § 4 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

§ 41-306A. Interstate insurance sales. — (1) A foreign insurer subject to the jurisdiction of another state's insurance department or insurance commissioner and licensed and authorized to transact health or disability insurance in its state of domicile may offer and sell an individual or group accident and sickness insurance policy as defined in [section 41-516, Idaho Code](#), in Idaho as long as that individual or group accident and sickness policy provides the mandatory coverages this title requires for insurers.

(2) The director may issue a certificate of authority to a foreign insurer to sell individual or group accident and sickness insurance policies in this state as long as that insurer is licensed in good standing in another state to sell individual or group accident and sickness insurance, remains licensed in good standing in that state to sell individual or group accident and sickness insurance and complies with the provisions of subsection (3) of this section. If an insurer is no longer licensed in good standing to sell individual or group accident and sickness insurance by its domiciled state, it shall be ineligible to do business in this state and its certificate of authority shall terminate immediately unless it obtains an independent certificate of authority in this state pursuant to chapter 3, title 41, Idaho Code, and complies with the provisions of this title.

(3) In order for a foreign insurer to offer and sell individual or group accident and sickness insurance policies to residents of this state, the foreign insurer agrees that any dispute regarding its policies, benefits, contracts or coverages purchased by Idaho residents shall be governed by Idaho law, shall be either litigated in Idaho or have an alternative dispute resolution conducted in Idaho and shall appoint the director as its agent for service of process pursuant to [section 41-333, Idaho Code](#). The foreign insurer submits to the jurisdiction of the department of insurance for all purposes under this title and is subject to all provisions of this title and rules promulgated thereunder applicable to insurers transacting accident and sickness insurance in Idaho. The foreign insurer must pay all fees and assessments provided by law under this title. The department of insurance may ensure that the forms used by a foreign insurer are appropriate and not misleading. Agents used by such foreign insurers are required to be licensed in Idaho.

(4) Insurers selling policies in Idaho pursuant to this section shall comply with the provisions of [section 41-402, Idaho Code](#), and remit the tax as provided in that section. Insurers selling policies in Idaho pursuant to this section shall be required to participate in the high risk reinsurance pool pursuant to chapter 55, title 41, Idaho Code.

(5) The department of insurance shall promulgate, adopt and enforce such rules and such methods of administration as may be necessary or proper to carry out the provisions of this section.

(6) The department of insurance is authorized to enter into compacts with other states for purposes of this section.

History.

[I.C., § 41-306A](#), as added by 2018, ch. 166, § 2, p. 339.

STATUTORY NOTES

Compiler's Notes.

S.L. 2018, ch. 166, § 4 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

§ 41-307. Authorization for investment purposes only. — A foreign insurer may make investments in this state without certificate of authority as provided by [section 30-21-502, Idaho Code](#). Such an insurer shall not be subject to any other provision of this code.

History.

1961, ch. 330, § 70, p. 645; am. 1980, ch. 197, § 27, p. 433; am. 1999, ch. 65, § 2, p. 168; am. 2017, ch. 58, § 20, p. 91.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 58, substituted “[section 30-21-502, Idaho Code](#)” for “[section 30-1-1501, Idaho Code](#)” at the end of the first sentence.

§ 41-308. General eligibility for certificate of authority. — To qualify for and hold authority to transact insurance in this state an insurer must be otherwise in compliance with this code and with its charter powers, and must be an incorporated stock insurer, or an incorporated mutual insurer, or a reciprocal insurer, of the same general type as may be formed as a domestic insurer under this code; except that:

(1) No insurer shall be authorized to transact insurance in this state which does not maintain reserves as required by chapter 6 (assets and liabilities) of this code [chapter 6, title 41, Idaho Code,] applicable to the kind or kinds of insurance transacted by such insurer, wherever transacted in the United States.

(2) Before granting authority to an insurer to transact insurance in this state, the director shall take into consideration the length of time the insurer has been transacting insurance; the net profit or loss experienced over the previous five (5) years; or any other factor which for good reason he believes could make the admittance of the insurer not in the best interest of the insurance-buying public.

(3) The director shall not grant or continue authority to transact insurance in this state as to any insurer the management of which is found by him to be untrustworthy, or so lacking in insurance experience as to make the proposed operation hazardous to the insurance-buying public; or which he has good reason to believe is affiliated directly or indirectly through ownership, control, reinsurance transactions or other insurance or business relations, with any person or persons whose business operations are or have been marked, to the detriment of policyholders or stockholders or investors or creditors or of the public, by manipulation or dissipation of assets, or manipulation of accounts, or of reinsurance, or by similar injurious actions.

History.

1961, ch. 330, § 71, p. 645; am. 1986, ch. 42, § 1, p. 126; am. 2006, ch. 49, § 2, p. 141.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 49, deleted “after a hearing held thereon” following “which is found by him” and following “insurance-buying public; or which”, in subsection (3).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the middle of subsection (1) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law Power of Legislature to Control.

Legislature may confine insurance business to corporations. *Intermountain Lloyds v. Diefendorf*, 51 Idaho 304, 5 P.2d 730 (1931).

RESEARCH REFERENCES

Idaho Law Review. — Anatomy of a Mortgage Meltdown: The Story of the Subprime Crisis, the Role of Fraud, and the Efficacy of the Idaho SAFE Act, Comment. 48 Idaho L. Rev. 123 (2011).

§ 41-309. Government-owned insurers not to be authorized. — No insurer the voting control or ownership of which is held in whole or substantial part by any government or governmental agency, or which is operated for or by any such government or agency, other than the Idaho state insurance fund, shall be authorized to transact insurance in this state. Membership in a mutual insurer, or subscribership in a reciprocal insurer, or ownership of stock of an insurer by the alien property custodian or similar official of the United States, or supervision of an insurer by public insurance supervisory authority shall not be deemed to be an ownership, control, or operation of the insurer for the purposes of this section.

History.

1961, ch. 330, § 72, p. 645; am. 1998, ch. 428, § 10, p. 1346; am. 2003, ch. 377, § 1, p. 1009; **I.C., § 41-309**, as added by 2003, ch. 377, § 4, p. 1009.

STATUTORY NOTES

Cross References.

State insurance fund, § 72-901 et seq.

Legislative Intent.

Section 1 of S.L. 2003, ch. 377, read: “The Legislature hereby declares its intent and understanding that the amendments of **Section 41-309, Idaho Code**, in Section 2 of this act clarify the original purpose and intent of **Section 41-309, Idaho Code**, and do not reflect a substantive change in the scope or application of that statute as it existed prior to the effective date of this act.”

Effective Dates.

Section 11 of S.L. 1998, ch. 428 declared an emergency and provided the act shall be in full force and effect on and after its passage and approval. Approved April 3, 1998.

Section 5 of S.L. 2003, ch. 377 provided that sections 1 and 2 of this act shall be in full force and effect on and after July 1 2003. Sections 3 and 4 of this act shall be in full force and effect on and after November 1, 2003.

§ 41-310. Payment of back taxes. — (1) In addition to other applicable requirements therefor, no insurer formerly an authorized insurer in this state and again seeking admission to this state as an authorized insurer shall be so authorized unless the insurer, as part of its application for such authority, includes a written statement duly sworn to by at least two (2) of its executive officers of all premiums received by the insurer with respect to insurance on subjects of insurance resident, located, or to be performed in this state, subsequent to its previous withdrawal for any cause from this state, and pays to the state premium tax thereon at the same rate and in the same amount as the insurer would have paid on such premiums had it continued to be an authorized insurer in this state during the period interim its withdrawal and its re-application for authority.

(2) Any insurer not theretofore authorized in this state which, within three (3) years prior to its application for authority to transact insurance in Idaho has transacted insurance in this state in violation of the laws of Idaho, shall not be granted such authority unless it is otherwise fully qualified therefor, files with the director a written statement sworn to by two (2) of its executive officers of all premiums received by it during such three (3) years with respect to insurance on subjects resident, located or to be performed in Idaho, and pays to the director as an additional fee for the filing of its application for certificate of authority, an amount of money equal to the premium tax which it would have paid to this state with respect to such premiums if it had been an authorized insurer in this state throughout such period.

History.

1961, ch. 330, § 73, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-311. Name of insurer. — (1) No insurer shall be formed, authorized or otherwise allowed to transact insurance in this state which has or uses a name or principal identifying name factor which is the same as or deceptively similar to that of another insurer earlier authorized or allowed to transact insurance in this state.

(2) No life insurer shall be authorized or otherwise allowed to transact insurance in this state which has or uses a name deceptively similar to that of another insurer authorized or otherwise allowed to transact insurance in this state within the preceding ten (10) years if life insurance policies originally issued by such other insurer are still outstanding in this state.

(3) No insurer shall hereafter be formed, newly authorized or otherwise allowed to transact insurance in this state which has or uses a name the same as or deceptively similar to the name of any foreign insurer doing business elsewhere than in this state if such foreign insurer has within the last preceding twelve (12) months signified its intention to secure incorporation in this state under such name, or do business as a foreign insurer in this state under such name by filing notice of such intention with the director, unless the written consent to the use of such name or deceptively similar name has been given by such foreign insurer.

(4) No insurer shall be authorized or otherwise allowed to transact insurance in this state which has or uses a name which tends to deceive or mislead as to the type of organization of the insurer.

(5) In case of conflict of names hereafter between two (2) insurers, or a conflict otherwise prohibited under this section, the director may permit, or shall require as a condition to the issuance of an original certificate of authority or other approval to transact insurance in this state to an applicant insurer, the insurer to use in this state such supplementation or modification of its name or such business name as may reasonably be necessary to avoid the conflict. No such name, supplementation or modification shall contain the principal identifying factor of the name of any other insurer already authorized or otherwise allowed to transact insurance in this state.

History.

1961, ch. 330, § 74, p. 645; am. 2004, ch. 91, § 1, p. 331.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-312. Combinations of insuring powers — One insurer. — An insurer which otherwise qualifies therefor may be authorized to transact any one (1) kind or combination of kinds of insurance as defined in chapter 5 of this code [chapter 5, title 41, Idaho Code], except:

(1) A life insurer may grant annuities and may be authorized to transact in addition only disability insurance; except, that the commissioner shall, if the insurer otherwise qualifies therefor, continue so to authorize any life insurer which immediately prior to the effective date of this code was lawfully authorized to transact in this state a kind or kinds of insurance in addition to life, and disability, insurances and annuity business.

(2) A reciprocal insurer shall not transact life insurance.

(3) A title insurer shall be a stock insurer, and shall not transact any other kind of insurance. This provision shall not prohibit the ceding of reinsurance by a title insurer to insurers other than mutual or reciprocal insurers.

History.

1961, ch. 330, § 75, p. 645.

STATUTORY NOTES

Compiler's Notes.

The phrase “the effective date of this code” in subsection (1) means the effective date of the insurance code, enacted by S.L. 1961, Chapter 330, effective January 1, 1962.

The bracketed insertion at the end of the introductory paragraph was added by the compiler to conform to the statutory citation style.

§ 41-313. Capital funds required — Foreign insurers and new domestic insurers. — (1) To qualify for and maintain authority to transact any one (1) kind of insurance (as defined in chapter 5[, title 41, Idaho Code]) or combination of kinds of insurance as shown below, a foreign insurer, or a domestic insurer shall possess and thereafter maintain unimpaired paid-up capital stock (if a stock insurer) or unimpaired basic surplus (if a mutual insurer or reciprocal insurer), and shall possess and thereafter maintain additional funds in surplus as follows:

Life	\$1,000,000	\$1,000,000
.....		
Disability	1,000,000	1,000,000
.....		
Life and disability	1,000,000	1,000,000
.....		
Property	1,000,000	1,000,000
.....		
General casualty	1,000,000	1,000,000
.....		
Marine and transportation	1,000,000	1,000,000
.....		
Vehicle	1,000,000	1,000,000
.....		
Surety	1,000,000	1,000,000
.....		
Any two of the following	kinds of insurance:	
Property, marine and transportation, general	casualty, vehicle, surety,	
disability	1,000,000	1,000,000
.....		

Title	500,000	500,000
.....		
Multiple lines (all insurance except life and title insurance)	1,000,000	1,000,000
.....		
Mortgage guaranty insurance	1,500,000	1,500,000
.....		

(2) An insurer holding a valid certificate of authority to transact insurance in this state shall comply with the paid-up capital stock or basic surplus and additional surplus requirements set forth in subsection (1) of this section. The director shall not grant such an insurer authority to transact any other or additional kinds of insurance unless it then fully complies with the requirements as to paid-up capital stock and additional surplus (if a stock insurer) or basic surplus and additional surplus (if a mutual or foreign reciprocal insurer) as applied to all the kinds of insurance which it then proposes to transact.

(3) Capital and surplus requirements are based upon all the kinds of insurance transacted by the insurer in any and all areas in which it operates or proposes to operate, whether or not only a portion of such kinds are to be transacted in this state.

(4) An insurance company holding a valid certificate of authority to transact insurance in this state immediately prior to January 1, 1995, shall have a period of three (3) years from and after that date within which to comply with the increase in capital and surplus requirements.

History.

1961, ch. 330, § 76, p. 645; am. 1969, ch. 214, § 6, p. 625; am. 1986, ch. 57, § 1, p. 164; am. 1993, ch. 279, § 3, p. 943; am. 1994, ch. 240, § 1, p. 751; am. 1995, ch. 96, § 1, p. 273.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in subsection (1) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

Section 13 of S.L. 1994, ch. 240 read: "Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993." Section 36 of S.L. 1993, ch. 194 provided, "For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer."

Effective Dates.

Section 9 of S.L. 1995, ch. 96 declared an emergency. Approved March 13, 1995.

§ 41-313A. Domestic reciprocal insurers with fewer than seven subscribers. — Domestic reciprocal insurers with fewer than seven (7) subscribers which insure only worker's compensation risks and which only issue fully assessable policies are required, in lieu of the paid-up capital stock or basic surplus and additional surplus requirements of [section 41-313, Idaho Code](#), to meet the security for payment of compensation standards set forth in [section 72-301, Idaho Code](#); provided however, the securities required pursuant to this section shall be deposited with the director of the department of insurance as opposed to the industrial commission; provided further, all other rules, regulations or statutory requirements applicable to domestic reciprocal insurers administered by the director of the department of insurance remain applicable to reciprocal insurers meeting the requirements of this section.

History.

[I.C., § 41-313A](#), as added by 1993, ch. 279, § 5, p. 943.

STATUTORY NOTES

Cross References.

Industrial commission, § 72-501 et seq.

Idaho Code § 41-314

**§ 41-314. Capital funds required — Old domestic insurers.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised S.L. 1961, ch. 330, § 77, was repealed by S.L. 1969, ch. 214, § 72.

§ 41-315. Permissible insuring combinations without additional capital funds. — (1) A life insurer may also grant annuities without additional capital or additional surplus.

(2) A disability insurer may also issue insurance against congenital defects, as defined in section 41-506(1)(l)[, Idaho Code], without additional capital or additional surplus.

(3) A casualty insurer may be authorized to transact also disability insurance without additional capital or additional surplus.

(4) A property insurer may without additional capital or additional surplus include such amount and kind of insurance against legal liability or injury, damage, or loss to the person or property of others, and for medical, hospital, and surgical expense related to such injury, as the director deems to be reasonably incidental to insurance of real property against fire and other perils under policies covering farm properties, or residential properties designated for occupancy by not more than four (4) families, with or without incidental office, professional, private school or studio occupancy by an insured whether or not the premium or rate charged for certain perils so covered is specified in the policy. Any provision of section 41-509[, Idaho Code] (limit of risk) to the contrary notwithstanding, no insurer authorized as to property insurance only shall pursuant to this subsection retain risk as to any one (1) subject of insurance as to hazards other than property insurance hazards, in an amount exceeding five per cent (5%) of its surplus to policyholders.

History.

1961, ch. 330, § 78, p. 645; am. 1969, ch. 214, § 7, p. 625.

STATUTORY NOTES

Compiler's Notes.

The name of the commissioner has been changed to director on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in subsection (2) and in the last sentence in subsection (4) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-316. Deposit — Foreign or alien insurers. — (1) This section shall apply as to all foreign and alien insurers.

(2) The director shall not authorize any foreign or alien insurer to transact insurance in this state unless it makes and thereafter maintains in trust in this state through the director for the protection of all its policyholders or of all its policyholders and creditors, a deposit of cash or securities eligible for deposit under [section 41-803, Idaho Code](#), in the amount of one million dollars (\$1,000,000), except that:

(a) As to foreign insurers, except foreign title insurers, in lieu of such Idaho deposit, the director shall accept the certificate in proper form of the public official having supervision over insurers in the insurer's state of domicile that:

(i) A like deposit by such insurer is being maintained in public custody or control for the protection generally of the insurer's policyholders or its policyholders and creditors; and

(ii) The insurer is a member in good standing of such state's insurance guaranty association or other legal entity created for the same purpose; or if a life or health insurer, the insurer is a member in good standing of such state's insurance guaranty association or other legal entity created for the same purpose, and such guaranty association does and shall provide protection for its own state's residents.

(b) As to foreign title insurers, in lieu of such Idaho deposit, the director shall accept the certificate or certificates in proper form from the public official or officials having supervision over title insurers in any other state or states to the effect that a like deposit or total deposits by such insurer, in an equal or greater amount than required in this section, are being maintained in public custody or control for the protection generally of the insurer's policyholders or its policyholders and creditors.

(c) As to alien insurers, in lieu of such deposit or part thereof in this state, the director shall accept evidence satisfactory to him that the insurer maintains within the United States by way of trust deposits with public depositaries, or in trust institutions acceptable to the director, assets

available for discharge of its United States insurance obligations, which assets shall be in an amount not less than the outstanding liabilities of the insurer arising out of its insurance transactions in the United States together with a surplus equal to the larger of the following sums:

(i) The largest deposit required by this code to be made by a foreign insurer transacting like kinds of insurance; or

(ii) One million dollars (\$1,000,000). Such surplus shall for all purposes under this code be deemed to be the “capital” or “surplus” of the insurer.

(3) Deposits of foreign or alien insurers in another state shall be in cash and/or securities of substantially as high quality as those eligible for deposit in this state under [section 41-803, Idaho Code](#).

(4) All such deposits in this state are subject to the applicable provisions of chapter 8 (administration of deposits), title 41, Idaho Code, except that the release and return of deposits brought about by changes to [section 41-316\(2\), Idaho Code](#), effective July 1, 1987, shall not require a hearing thereon as required under [section 41-812\(2\), Idaho Code](#).

(5) Any foreign or alien insurer which requires that its agents maintain a separate trust account for transactions involving that insurer shall make and thereafter maintain in trust in this state, through the director, for the protection of all its policyholders and agents, a deposit of cash or securities eligible for deposit under [section 41-803, Idaho Code](#), in the amount of twenty percent (20%) of its gross written premiums, upon which such insurer is subject to the premium tax of this state under [section 41-402, Idaho Code](#).

(6) A foreign or alien insurer holding a valid certificate of authority to transact insurance in this state immediately prior to January 1, 1995, shall have a period of two (2) years from and after that date within which to comply with any increase in deposit requirements.

History.

1961, ch. 330, § 79, p. 645; am. 1984, ch. 125, § 1, p. 300; am. 1986, ch. 57, § 2, p. 164; am. 1987, ch. 291, § 1, p. 616; am. 1994, ch. 240, § 2, p. 751; am. 1995, ch. 117, § 1, p. 416; am. 1995, ch. 289, § 1, p. 967; am. 2004, ch. 90, § 1, p. 325.

STATUTORY NOTES

Amendments.

This section was amended by two 1995 acts which appear to be compatible and have been compiled together.

The 1995 amendment, by ch. 117, § 1, in subdivision (2)(a), added “except foreign title insurers”, added the present subdivision (2)(b) and designated the former subdivision (2)(b) as the present subdivision (2)(c).

The 1995 amendment, by ch. 289, § 1, added subsection (6).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

RESEARCH REFERENCES

ALR. — Construction and operation of state retaliatory statutes imposing special taxes or fees on foreign insurers doing business within state, [30 A.L.R.4th 873](#).

§ 41-316A. Deposit — General requirement — Domestic insurers. —
This section shall apply to all domestic insurers.

(1) The director shall not authorize the formation of a new domestic insurer or the redomestication to this state of an insurer unless it makes and thereafter maintains in trust in this state through the director for the protection of all its policyholders and creditors, a deposit of cash or securities eligible for deposit under [section 41-803, Idaho Code](#), in an amount of the minimum capital for a stock insurer and basic surplus of a mutual or reciprocal insurer, as required in sections 41-313 and 41-2652, Idaho Code.

(2) A domestic insurer holding a valid certificate of authority to transact insurance in this state immediately prior to January 1, 1994, shall have a period of three (3) years from and after that date within which to comply with any increase in deposit requirements.

History.

[I.C., § 41-316A](#), as added by 1994, ch. 240, § 3, p. 751.

STATUTORY NOTES

Compiler's Notes.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

**§ 41-317. Special deposit — Workmen's compensation insurers.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 80, p. 645; am. 1973, ch. 275, § 1, p. 587; am. 1986, ch. 247, § 1, p. 666, was repealed by S.L. 2004, ch. 90, § 2.

§ 41-318. Cooperation with the department of health and welfare. —

(1) A health insurer that provides disability insurance as defined in [section 41-503, Idaho Code](#), including self-insured plans, group health plans as defined in section 607(1) of the employee retirement income security act of 1974, service benefit plans, managed care organizations, pharmacy benefit managers or other parties that are by statute, contract or agreement legally responsible for payment of a claim for a health care item or service with respect to medical assistance programs under chapter 2, title 56, Idaho Code, shall, as a condition of doing business in the state of Idaho, cooperate with the Idaho department of health and welfare by doing the following:

(a) Provide, with respect to an individual who is eligible for or who is or has been provided medical assistance under chapter 2, title 56, Idaho Code, within sixty (60) days of a request of the department, information to determine the period the individual or the individual's spouse or dependents are, or have been, covered by the insurer and the nature of that coverage. The information shall include the name and address of the insurer and the identifying number of the health care insurance plan. The format of the information provided shall include the data elements, medium and frequency of reporting, any costs of the insurer to be reimbursed and procedures that will be followed when a data match is found;

(b) Accept the department's right of recovery on behalf of the state of Idaho, and the assignment to the department of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under chapter 2, title 56, Idaho Code;

(c) Respond to any inquiry by the department regarding a claim for payment for any health care item or service submitted not later than three (3) years after the date of the provision of the health care item or service; and

(d) Agree not to deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

(i) The claim is submitted by the department within the three (3) year period beginning on the date on which the item or service was furnished; and

(ii) Any action by the department to enforce its rights with respect to the claim is commenced within six (6) years after the department's submission of the claim.

(2) Failure to cooperate with the department as set forth in subsection (1) of this section shall subject the insurer to suspension or revocation of its certificate of authority pursuant to [section 41-326, Idaho Code](#).

History.

[I.C., § 41-318](#), as added by 2008, ch. 147, § 1, p. 432.

STATUTORY NOTES

Prior Laws.

Former § 41-318, which comprised 1961, ch. 330, § 81, p. 645, was repealed by S.L. 1994, ch. 240, § 4, effective March 30, 1994.

Cross References.

Department of health and welfare, § 56-1001 et seq.

Federal References.

Section 607(1) of the employee retirement income security act of 1974, referred to in the introductory paragraph in subsection (1), is codified as [29 U.S.C.S. § 1167\(1\)](#).

§ 41-319. Application for certificate of authority. — To apply for an original certificate of authority an insurer shall file with the director its application therefor, accompanied by the applicable fees set forth by rule pursuant to [section 41-401, Idaho Code](#), showing its name, location of its home office or principal office in the United States (if an alien insurer), the kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile, and such additional information as the director may reasonably require, together with the following documents, as applicable:

(1) If a foreign corporation, one (1) copy (photostatic copy or similar form of reproduction) of its corporate charter, articles of incorporation or other charter documents, with all amendments thereto, currently certified by the public official with whom the originals are on file in the state or country of domicile. If a domestic corporation, three (3) copies pursuant to [section 41-2804, Idaho Code](#).

(2) If a foreign corporation, one (1) copy (photostatic copy or similar form of reproduction) of its bylaws as amended, certified by the insurer's corporate secretary. If a domestic corporation, three (3) copies (photostatic copies or similar form of reproduction) of its bylaws as amended, certified by the insurer's corporate secretary.

(3) If a reciprocal insurer, a copy of the power of attorney of its attorney in fact, and a copy of its subscribers' agreement, if any, both certified by the attorney in fact; and if a domestic reciprocal insurer, the declaration provided for in [section 41-2908, Idaho Code](#).

(4) A complete copy of its financial statement as of not earlier than the December 31 next preceding in form as customarily used in the United States by like insurers, sworn to by at least two (2) executive officers of the insurer, or certified by the public insurance supervisory official of the insurer's state of domicile or of entry into the United States.

(5) Copy of report of last examination, if any, made of the insurer within not more than three (3) years next preceding, certified by the public insurance supervisory official of the insurer's state of domicile or of entry

into the United States; or, in the case of newly formed insurers, copy of the report of the “qualifying” examination of the insurer, similarly certified. Provided, however, that if the law of the applicant’s state of domicile requires that examinations shall be completed in a period of more than three (3) years or does not specify any period of time for examinations, then the applicant shall provide a copy of a report within not more than the five (5) years next preceding.

(6) Appointment of the director pursuant to [section 41-333, Idaho Code](#), as its attorney to receive service of legal process.

(7) If a foreign insurer, a certificate of the public insurance supervisory official of its state or country of domicile showing that it is authorized to transact in such state or country the kind or kinds of insurance proposed to be transacted in this state.

(8) If an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records.

(9) If a foreign insurer, certificate as to deposit if to be tendered pursuant to [section 41-316, Idaho Code](#).

(10) If a life or disability insurer, one (1) copy of the insurer’s rate book and of each form of policy proposed to be issued in this state.

History.

1961, ch. 330, § 82, p. 645; am. 1963, ch. 120, § 1, p. 348; am. 1983, ch. 188, § 1, p. 508; am. 2001, ch. 85, § 3, p. 211; am. 2004, ch. 89, § 1, p. 324; am. 2004, ch. 90, § 3, p. 325.

STATUTORY NOTES

Amendments.

This section was amended by two 2004 acts which appear to be compatible and have been compiled together.

The 2004 amendment, by ch. 89, in the first sentence, inserted “foreign” preceding “corporation”, substituted “one (1) copy (photostatic copy or similar form of reproduction)” for “two (2) copies (photostatic copies or similar form of reproduction)”, added the last sentence; rewrote subsection

(2) which read: “If a domestic insurer or mutual insurer, one (1) copy (photostatic copy or similar form of reproduction) of its bylaws as amended, certified by the insurer’s corporate secretary”; deleted former subsection (8) which read: “If a worker’s compensation insurer, tender of the special deposit required under [section 41-317, Idaho Code](#)”; redesignated former subsections (9) through (11) as present subsections (8) through (11) and deleted former subsection (12) which read: “A certificate of the insurer granting authority to an officer or authorized representative of the insurer to appoint and remove agents.”

The 2004 amendment, by ch. 90, deleted former subsection (8) which read “If a worker’s compensation insurer, tender of the special deposit required under [section 41-317, Idaho Code](#)”; redesignated former subsections (9) through (12) as subsections (8) through (11).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law

[Loaning money by foreign insurer.](#)

[Principal place of business.](#)

Loaning Money by Foreign Insurer.

Loaning money being a concomitant part of the business of an insurance company, such companies were not restricted to the insurance business as distinguished from loaning money. [Union Cent. Life Ins. Co. v. Rahn, 63 Idaho 243, 118 P.2d 717 \(1941\).](#)

Principal Place of Business.

Ada county, being the official residence of the commissioner of finance (director of the department of insurance), was the principal place of business in the state of Idaho for service of process on foreign insurance

companies. *Union Cent. Life Ins. Co. v. Rahn*, 63 Idaho 243, 118 P.2d 717 (1941).

§ 41-320. Consideration of application. — An application for a certificate of authority shall be examined by the director, and if he finds the application to be complete and that the documents included therewith are otherwise in proper order, he shall forward the applicant insurer's articles of incorporation and by-laws, if any, or copy of the power of attorney if a reciprocal insurer, and the insurer's appointment of the director as process agent to the attorney general for examination. The attorney general shall examine the documents, and if found by him to be in accordance with the requirements of this code and not inconsistent with the constitution of this state he shall so certify in an opinion to the director.

History.

1961, ch. 330, § 83, p. 645.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-321. Filing of articles of incorporation. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 84, p. 645, was repealed by S.L. 1985, ch. 251, § 1.

§ 41-322. Issuance or refusal of certificate of authority. — (1) If upon completion of its application the director finds, from the application, the attorney general's opinion referred to in section 41-320[, Idaho Code], and such other investigation and information as he may make or acquire, that the insurer is fully qualified for and entitled thereto under this code, he shall issue to the insurer a proper certificate of authority; if he does not so find, the director shall issue his order refusing such authority.

(2) The director and attorney general shall take all necessary action therefor as specified in section 41-320[, Idaho Code,] and this section, and shall either issue or refuse to issue a certificate of authority within a reasonable time after the completion of the application for such authority.

(3) The certificate of authority, if issued, shall specify the kind or kinds of insurance the insurer is authorized to transact in this state. At the insurer's request, the director may issue authority limited to particular types of insurance or insurance coverages within the scope of a kind of insurance as defined in chapter 5 of this code [chapter 5, title 41, Idaho Code].

History.

1961, ch. 330, § 85, p. 645.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in subsections (1), (2), and (3) were added by the compiler to conform to the statutory citation style.

§ 41-322A. Certificates of authority for deposit guarantee corporations. — Upon the application of a deposit guarantee corporation, the director may issue a certificate of authority to a corporation authorized to issue share and deposit insurance contracts upon such terms and conditions as the director may prescribe by rule or regulation promulgated in accordance with [section 41-211, Idaho Code](#), and chapter 52, title 67, Idaho Code.

History.

[I.C., § 41-322A](#), as added by 1983, ch. 177, § 2, p. 484.

§ 41-323. What certificate evidences — Ownership of certificate. —

(1) An insurer's subsisting certificate of authority is evidence of its authority to transact in this state the kind or kinds of insurance specified therein, either as direct insurer or as reinsurer or as both.

(2) Although issued to the insurer the certificate of authority is at all times the property of the state of Idaho. Upon any expiration, suspension, or termination thereof the insurer shall promptly deliver the certificate of authority to the director.

History.

1961, ch. 330, § 86, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-324. Continuance, expiration, or reinstatement of certificate of authority. — (1) A certificate of authority shall continue in force as long as the insurer is entitled thereto under this code and until suspended or revoked by the director, or terminated at the request of the insurer; subject, however, to continuance of the certificate by the insurer each year by:

(a) Payment prior to March 1 of the continuation fee as required by regulation of the department of insurance; and

(b) Due filing by the insurer of its annual statement for the calendar year preceding as required under [section 41-335, Idaho Code](#); and

(c) Payment by the insurer of premium taxes with respect to the preceding calendar year as required by sections 41-402 and 41-403, Idaho Code.

(2) If not so continued by the insurer, its certificate of authority shall expire as at midnight on the March 31 next following such failure of the insurer to continue it in force. The director shall promptly notify the insurer of the occurrence of any failure resulting in impending expiration of its certificate of authority.

(3) The director may, in his discretion, upon the insurer's request made within three (3) months after expiration, reinstate a certificate of authority which the insurer has inadvertently permitted to expire, after the insurer has fully cured all its failures which resulted in the expiration, and upon payment by the insurer of the fee for reinstatement specified in [section 41-401, Idaho Code](#) (fee schedule). Otherwise the insurer shall be granted another certificate of authority only after filing application therefor and meeting all other requirements as for an original certificate of authority in this state.

History.

1961, ch. 330, § 87, p. 645; am. 1991, ch. 277, § 3, p. 717.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 41-403, Idaho Code, referred to at the end of paragraph (1)(c), was repealed by S.L. 2004, ch. 356, § 3, effective January 1, 2010.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-325. Amendment of certificate of authority. — The director may at any time amend an insurer's certificate of authority to accord with changes in the insurer's charter or insuring powers.

History.

1961, ch. 330, § 88, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-326. Suspension or revocation of certificate of authority — Mandatory grounds. — (1) The director shall refuse to continue, or shall suspend or revoke, an insurer's certificate of authority:

(a) If such action is required by any provision of this code; or (b) If a foreign insurer, it no longer meets the requirements for the authority, on account of deficiency of assets or otherwise; or if a domestic insurer, it has failed to cure an impairment of capital or surplus within the time allowed therefor by the director under this code; or (c) If the insurer knowingly exceeds its charter powers or powers granted under its certificate of authority; or (d) If the insurer's certificate of authority to transact insurance therein is suspended or revoked by its state of domicile, or state of entry into the United States if an alien insurer.

(2) Except in cases of insolvency or impairment of required capital or surplus, or suspension or revocation by another state as referred to in subdivision (d) above, the director shall so refuse, suspend, or revoke the certificate of authority only after a hearing granted to the insurer thereon, unless the insurer waives such hearing in writing.

History.

1961, ch. 330, § 89, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-327. Administrative penalty — Suspension or revocation of certificate of authority — Discretionary and special grounds. — (1) The director may, in his discretion, impose an administrative penalty not to exceed five thousand dollars (\$5,000) for deposit in the general fund of the state of Idaho, or refuse to continue or suspend or revoke an insurer's certificate of authority if he finds after a hearing thereon that the insurer has violated or failed to comply with any lawful order of the director, or any provision of this code other than those for which suspension or revocation is mandatory.

(2) The director shall suspend or revoke an insurer's certificate of authority on any of the following grounds if he finds after a hearing thereon that the insurer:

(a) Is in unsound condition, or in such condition or using such methods and practices in the conduct of its business as to render its further transaction of insurance in this state hazardous or injurious to its policyholders or to the public.

(b) Has failed, after written request therefor by the director, to remove or discharge an officer or director who has been convicted of any crime involving fraud, dishonesty, or that is otherwise deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#).

(c) With such frequency as to indicate its general business practice in this state, has without just cause refused to pay claims arising under coverages provided by its policies, whether the claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to such third person, or, with like frequency, without just cause compels insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or such an insured to obtain full payment or settlement of such claims.

(d) Is affiliated with and under the same general management, or interlocking directorate, or ownership as another insurer which transacts direct insurance in this state without having a certificate of authority therefor, except as permitted under this code.

(e) Refuses to be examined, or if its directors, officers, employees, or representatives refuse to submit to examination relative to its affairs, or to produce its accounts, records, and files for examination by the director when required, or refuses to perform any legal obligation relative to the examination.

(f) Has failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance, or undertaking issued or guaranteed by it within thirty (30) days after the judgment became final, or within thirty (30) days after time for taking an appeal has expired, or within thirty (30) days after dismissal of an appeal before final determination, whichever date is latest.

(3) The director may, in his discretion and without advance notice or a hearing thereon, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings have been commenced in any state by the public insurance supervisory official of such state.

History.

1961, ch. 330, § 90, p. 645; am. 1975, ch. 246, § 1, p. 658; am. 2020, ch. 175, § 6, p. 500.

STATUTORY NOTES

Cross References.

General fund, § 67-1205.

Amendments.

The 2020 amendment, by ch. 175, in subsection (2), substituted “that is otherwise deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#)” for “like moral turpitude” at the end of subsection (b).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Sanctions.

The director of the department of insurance determined that (1) through its agents, insurance company had solicited insurance in Idaho, in violation of § 41-1030; (2) by its acceptance of customer's application and its issuance of an insurance policy to her, insurance company had transacted insurance in Idaho without a certificate of authority, in violation of § 41-305(1); and (3) insurance company had paid a sales commission to agents who were not authorized to make that sale of insurance, in violation of § 41-1063(1) (now repealed); pursuant to the authority granted in this section, the director assessed an administrative penalty against insurance company in the amount of \$1,000 which penalty was found to be reasonable. [Pan Am. Assurance Co. v. Department of Ins., 121 Idaho 884, 828 P.2d 913 \(Ct. App. 1992\).](#)

Where insurance company was found to have committed acts specifically defined as acts for which an insurer is held strictly accountable, although the violation of §§ 41-305, 41-1030, and 41-1063 (now repealed) arguably resulted from the agents' submission of a false application, insurance company nonetheless was responsible under these sections and was subject to sanctions by the director of the department of insurance. [Pan Am. Assurance Co. v. Department of Ins., 121 Idaho 884, 828 P.2d 913 \(Ct. App. 1992\).](#)

§ 41-328. Order and notice of suspension, revocation or refusal — Effect upon agents' authority. — (1) All suspensions or revocations of, or refusals to continue, an insurer's certificate of authority shall be by the director's order given to the insurer as provided by section 41-212[, Idaho Code].

(2) Upon suspending or revoking or refusing to continue the insurer's certificate of authority the director shall forthwith give notice thereof to the insurer's agents in this state of record in the department, and shall likewise suspend or revoke the authority of such agents to represent the insurer.

(3) In his discretion the director may likewise publish notice of such suspension, revocation or refusal in one or more newspapers of general circulation in this state.

History.

1961, ch. 330, § 91, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-329. Duration of suspension — Insurer's obligations during suspension period — Reinstatement. — (1) Suspension of an insurer's certificate of authority shall be for such period as the director specifies in the order of suspension, but not to exceed one (1) year. During the suspension the director may rescind or shorten the suspension by his further order.

(2) During the suspension period the insurer shall not solicit or write any new business in this state, but shall file its annual statement, pay fees, licenses, and taxes as required under this code, and may service its business already in force in this state, as if the certificate of authority had continued in full force.

(3) Upon expiration of the suspension period, if within such period the certificate of authority has not terminated, the insurer's certificate of authority shall automatically reinstate unless the director finds that the causes of the suspension have not terminated, or that the insurer is otherwise not in compliance with the requirements of this code, and of which the director shall give the insurer notice not less than thirty (30) days in advance of the expiration of the suspension period after which time the director may issue a new order of suspension. If not reinstated or if a new order of suspension is not issued, the certificate of authority shall be deemed to have terminated as of the end of the suspension period.

(4) Upon reinstatement of the insurer's certificate of authority, the authority of its agents in this state to represent the insurer shall likewise reinstate. The director shall promptly notify the insurer and its agents in this state of record in the department, of such reinstatement. If pursuant to [section 41-328\(3\), Idaho Code](#), the director has published notice of such suspension he shall in like manner publish notice of the reinstatement.

History.

1961, ch. 330, § 92, p. 645; am. 2004, ch. 88, § 1, p. 323.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-330. Impaired insurers — Notice to agents — Penalty. — (1) Upon suspension, revocation or refusal to continue the certificate of authority of an insurer on account of deficiency of assets (if a foreign insurer) or failure to cure an impairment of the capital stock (if a stock insurer) or surplus (if a mutual or reciprocal) of a domestic insurer, as provided under section 41-326(1)(b)[, Idaho Code], every officer and director of the insurer must, either separately or jointly with one or more of the others and within four (4) days after notice of such suspension, revocation or refusal was given to the insurer by the director, notify by any available means every person authorized by the insurer, as of immediately prior to such suspension, revocation or refusal, to write business for the insurer in Idaho, immediately to cease such writing; and each such person so notified shall immediately cease to write any further business for the insurer in Idaho.

(2) Each individual made responsible for such notification under the foregoing subsection, who fails so to notify, and every person so authorized who, after being so notified or otherwise being informed as to such impairment or suspension, revocation, or refusal, solicits or writes further business for the insurer, is guilty of a felony and upon conviction shall be punished by a fine of not exceeding ten thousand dollars (\$10,000) or by imprisonment in the Idaho state penitentiary for a term of not exceeding ten (10) years, or by both such fine and imprisonment.

(3) This section does not apply to any person or persons, whomsoever, who has been appointed as and is acting as rehabilitator or receiver of the insurer in judicial proceedings in a court of the United States or of the state of Idaho.

History.

1961, ch. 330, § 93, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the middle of subsection (1) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-331. Impaired insurers — Liability of officers. — The president and each director of a stock insurer who, after knowing that the insurer's capital is impaired, permits or assents in the writing of new business by the insurer in this state during the existence of such impairment, shall, together with their respective estates, be severally and jointly liable for the amount of any loss or losses which may be incurred by the insured under any such new insurance.

History.

1961, ch. 330, § 94, p. 645.

§ 41-332. Foreign insurers exempt from corporation laws governing admission of foreign corporations. — A foreign insurer authorized to transact insurance in this state and fully complying with this code shall be exempt from complying with the provisions of [sections 30-21-501 through 30-21-512, Idaho Code](#).

History.

1961, ch. 330, § 95, p. 654; am. 1980, ch. 197, § 28, p. 433; am. 1999, ch. 65, § 3, p. 168; am. 2017, ch. 58, § 21, p. 91.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 58, substituted “[sections 30-21-501 through 30-21-512, Idaho Code](#)” for “[sections 30-1-1501 through 30-1-1533, Idaho Code](#)”.

Effective Dates.

Section 34 of S.L. 1980, ch. 197 read: “(1) Section 1 and sections 3 through 33 of this act shall be in full force and effect on and after July 1, 1980.

“(2) Section 2 of this act shall be in full force and effect on and after July 1, 1981.”

CASE NOTES

Decisions Under Prior Law Lending of Money.

Foreign insurance company, by lending money, did not remove itself from the operation of section exempting insurance companies from compliance with general statutes governing incorporation of foreign businesses, lending money being a concomitant part of the business of insurance. [Union Cent. Life Ins. Co. v. Rahn, 63 Idaho 243, 118 P.2d 717 \(1941\)](#).

§ 41-333. Director as process agent for foreign insurers and domestic reciprocal insurers. — (1) Before the director shall issue to it a certificate of authority to transact insurance in this state each foreign and alien insurer and each domestic reciprocal insurer shall appoint the director and his successors in office, as its attorney to receive service of legal process issued against the insurer in this state. The appointment shall be made on a form as designated and furnished by the director. The appointment shall be irrevocable, shall bind the insurer and any successor in interest or to the assets or liabilities of the insurer, and shall remain in effect as long as there is in force any contract of the insurer in this state or any obligation of the insurer arising out of its transactions in this state.

(2) Service of such process against a foreign or alien insurer shall be made only by service thereof upon the director, or his deputy, or other person in charge of his office during his absence.

(3) At time of application for a certificate of authority the insurer shall file the appointment with the director, together with designation of the person to whom process against it served upon the director is to be forwarded. The insurer may change such designation by a new filing.

History.

1961, ch. 330, § 96, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Decisions Under Prior Law [Commissioner of finance as statutory agent.](#)

[Nonappealable orders.](#)

[Principal place of business.](#)

Surety companies.

Commissioner of Finance as Statutory Agent.

The commissioner of finance was the statutory agent of an insurance company under § 40-502 (since repealed), and service on him was binding. *Voellmack v. Northwestern Mut. Life Ins. Co.*, 60 Idaho 412, 92 P.2d 1076 (1939).

The appointment of the commissioner of finance as statutory agent by foreign insurance companies for the service of process before transacting business in the state was as much a compliance with constitutional requirement that a foreign corporation have an authorized state agent on whom process may be served as is compliance with the statute requiring every foreign corporation to file duly certified copies of articles of incorporation for record with the secretary of state and recorder of the county wherein its principal place of business in the state is located. *Union Cent. Life Ins. Co. v. Rahn*, 63 Idaho 243, 118 P.2d 717 (1941).

Nonappealable Orders.

An appeal would not lie in an action to recover against a foreign insurance company where summons had been served on the state insurance commissioner (now director) on behalf of the defendant insurance company by registered mail and service was completed on that day where a minute entry considered an order for judgment was later vacated by order of court, such order not being considered a special order made as final judgment. *McPheters v. Central Mut. Ins. Co.*, 83 Idaho 472, 365 P.2d 47 (1961).

Principal Place of Business.

Ada county, being the official residence of the commissioner of finance (director of the department of insurance), was the principal place of business in the state of Idaho for service of process on foreign insurance companies. *Union Cent. Life Ins. Co. v. Rahn*, 63 Idaho 243, 118 P.2d 717 (1941).

Surety Companies.

Compliance with § 40-502 (since repealed) by foreign surety company relieves it from compliance with general law regulating foreign

corporations doing business in this state. *American Surety Co. v. Ada County Dist. Court*, 43 Idaho 589, 254 P. 515 (1927).

§ 41-334. Serving process — Time to plead. — (1) Duplicate copies of legal process against an insurer for whom the director is attorney, shall be served upon him either by a person competent to serve a summons or by registered or certified mail. At the time of service the plaintiff shall pay to the director an appropriate fee not in excess of thirty dollars (\$30.00) which fee shall be determined by rule and regulation.

(2) The director shall forthwith send one (1) of the copies of the process, by registered or certified mail with return receipt requested, to the person designated for the purpose by the insurer in its most recent such designation filed with the director.

(3) The director shall keep a record of the day of service upon him of all legal process. No proceedings shall be had against the insurer, and the insurer shall not be required to appear, plead, or answer until the expiration of thirty (30) days after the date of service upon the director.

(4) Process served upon the director and copy thereof forwarded as in this section provided shall for all purposes constitute valid and binding service thereof upon the insurer.

History.

1961, ch. 330, § 97, p. 645; am. 1972, ch. 369, § 5, p. 1072; am. 1977, ch. 142, § 1, p. 303; am. 1979, ch. 122, § 1, p. 375; am. 1988, ch. 345, § 1, p. 1024.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-335. Annual statement. — (1) Each authorized insurer shall annually on or before March 1, or within any extension of time therefor, not to exceed thirty (30) days, which the director for good cause may have granted, file with the director a full and true statement of its financial condition, transactions and affairs as of the preceding December 31. Unless otherwise required by the director, the statement is to be prepared in accordance with the national association of insurance commissioners' (NAIC) annual statement instructions and the NAIC's accounting practices and procedures manual, utilizing the version of the manual effective January 1, 2004, and any subsequent revisions that are adopted for use by the director by rule, administrative order or bulletin, and is to be submitted on the NAIC annual statement blank form, and any statement, form or other information relating to the compensation of any officer, director or employee will be deemed confidential. At the seasonable request of a domestic insurer the director shall furnish to the insurer the blank form of annual statement to be used by it. The statement shall be verified by the oath of the insurer's president or vice president, and secretary or actuary as applicable, or if a reciprocal insurer, by the oath of the attorney in fact or its like officers if a corporation.

(2) The statement of an alien insurer shall be verified by its United States manager or other officer duly authorized, and shall relate only to the insurer's transactions and affairs in the United States unless the director requires otherwise. If the director requires a statement as to the insurer's affairs throughout the world, the insurer shall file such statement with the director as soon as reasonably possible.

(3) Any insurance company licensed to do business in this state which neglects to file or fails to file in the time prescribed by statute its annual statement or supplemental summary statement requested by the director shall be subject to a penalty of twenty-five dollars (\$25.00) per day for each day in default. This penalty will be in addition to any administrative penalty which may be assessed pursuant to sections 41-327 and 41-324, Idaho Code.

(4) Each domestic insurer authorized to do business in this state shall annually, on or before March 1 of each year, file with the NAIC its annual financial statement in a form prescribed by the director along with any additional filings prescribed by the director for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by this code. Any amendments or addenda to the annual statement shall also be filed with the NAIC.

(5) At time of filing, the insurer shall pay to the director the fee for filing its statement as prescribed by rule of the department of insurance.

(6) The financial statements filed with the director pursuant to this section, with the exception of information relating to officer, director, or employee compensation referred to in subsection (1) of this section, are public records and available to the public, notwithstanding the exemptions from disclosure provided in chapter 1, title 74, Idaho Code.

History.

1961, ch. 330, § 98, p. 645; am. 1991, ch. 277, § 1, p. 717; am. 1995, ch. 289, § 2, p. 967; am. 1996, ch. 68, § 1, p. 212; am. 1999, ch. 30, § 11, p. 41; am. 2004, ch. 93, § 1, p. 337; am. 2005, ch. 75, § 1, p. 254; am. 2015, ch. 141, § 108, p. 379.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in subsection (6)

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

As to national association of insurance commissioners, referred to in subsections (1) and (4), see <http://naic.org>.

For Idaho administrative code provisions relating to annual financial statements, see [IDAPA 18.01.62](#).

§ 41-336. Review of annual statement — Additional information. —

(1) As soon as reasonably possible after the insurer has filed its annual statement with him, the director shall review the same and require correction of such errors or omissions in the statement as appear from such review.

(2) Any company transacting business in this state may be required by the director, when he considers such action to be necessary for the protection of policyholders, creditors, shareholders or claimants, to file a supplementary summary financial statement in a format prescribed by the director. Supplementary summary financial statements shall be due within sixty (60) days after notice is mailed to the company by the director requesting such statement. No company shall be required to file more than four (4) supplementary summary statements during any consecutive twelve (12) month period. The director may, at his discretion, require the annual statement be certified by an independent actuary deemed competent by the director or by an independent certified public accountant.

(3) In addition to information called for and furnished in connection with its annual statement, an insurer shall promptly furnish to the director such other or further information with respect to any of its transactions or affairs as the director may from time to time request in writing.

History.

1961, ch. 330, § 99, p. 645; am. 1991, ch. 277, § 2, p. 717.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-336A — 41-336D. Statistical reports — Disposition — Penalties — Fees. [Repealed.]

STATUTORY NOTES

Prior Laws.

Another former § 41-336A, which comprised **I.C., § 41-336A**, as added by 1976, ch. 115, § 1, p. 451, was repealed by S.L. 1979, ch. 107, § 1.

Another former § 41-336B, which comprised **I.C., § 41-336B**, as added by 1977, ch. 235, § 1, p. 709, was repealed by S.L. 1979, ch. 107, § 1.

Compiler's Notes.

The following sections were repealed by S.L. 1996, ch. 305, § 1, effective July 1, 1996:

41-336A. (**I.C., § 41-336A**, as added by 1979, ch. 107, § 2, p. 341; am. 1986, ch. 54, § 1, p. 159; am. 1987, ch. 278, § 17, p. 571; am. 1988, ch. 162, § 1, p. 292.)

41-336B. (**I.C., § 41-336B**, as added by 1986, ch. 54, § 2, p. 159; am. 1988, ch. 162, § 2, p. 292.)

41-336C. (**I.C., § 41-336C**, as added by 1986, ch. 54, § 3, p. 159.)

41-336D. (**I.C., § 41-336D**, as added by 1986, ch. 54, § 4, p. 159.)

§ 41-337. Resident agent, countersignature law. — (1) Except as provided in [section 41-338, Idaho Code](#), no authorized insurer shall make, write, place or cause to be made, written or placed, any policy or contract of insurance or indemnity of any kind or character, or a general or floating policy covering risks on property located in Idaho, liability created by or accruing under the laws of this state, or undertakings to be performed in this state, except through its resident insurance agents licensed as provided in this code, who shall countersign or cause a facsimile of his signature to be placed on all policies or indemnity contracts so issued, and who shall keep a record of the same, containing the usual and customary information concerning the risk undertaken and the full premium paid or to be paid therefor, to the end that the state may receive the taxes required by law to be paid on premiums collected for insurance on property or undertakings located in this state. When two (2) or more insurers issue a single policy of insurance the policy may be countersigned on behalf of all insurers appearing thereon by a licensed agent, resident in this state, of any one such insurer.

(2) The agent may grant a power of attorney in writing to an individual who is twenty-one (21) years or more of age authorizing such person to countersign or cause a facsimile of the agent's signature to be placed on policies and indorsements in his name and behalf. The power of attorney shall be acknowledged by the agent under oath before a notary public and shall be kept on file in the agent's office.

History.

1961, ch. 330, § 100, p. 645; am. 1969, ch. 214, § 8, p. 625; am. 1977, ch. 142, § 2, p. 303; am. 1978, ch. 90, § 1, p. 167; am. 1984, ch. 60, § 1, p. 108.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 1984, ch. 60 declared an emergency. Approved March 19, 1984.

CASE NOTES

Apparent authority.

Parol agreements.

Apparent Authority.

The insurer was estopped from denying that the insurance agent was its agent and from denying responsibility for any errors committed by the insurer, where the insured relied upon the agent's apparent authority to receive and forward claims, and the agent engaged in all of the activities that would cloak it with the apparent authority to process the insured's claim. *County of Kootenai v. Western Cas. & Sur. Co.*, 113 Idaho 908, 750 P.2d 87 (1988).

Parol Agreements.

An insurer who clothes its local general agent with apparent authority to bind the company on his parol insurance agreements, in the absence of notice of or reason to suspect the lack of such authority on the part of one attempting to purchase insurance from such agent, is bound by the agent's representation to such prospective insured that he is covered. *Huppert v. Wolford*, 91 Idaho 249, 420 P.2d 11 (1966).

Assurance to the policy holder by the resident agent of a foreign insurance company that a workman's compensation policy would be renewed automatically each year was binding upon the company at the anniversary date of the policy two years later, even though the agency had been terminated, in the absence of notice to the policy holder of such termination or that the policy would not be renewed. *Martin v. Argonaut Ins. Co.*, 91 Idaho 885, 434 P.2d 103 (1967).

Decisions Under Prior Law

Agent of foreign company.

Bond.

Commission for countersigning policies.

Agent of Foreign Company.

An agent of a foreign insurance company, who had power to solicit and take applications, collect premiums, and countersign and deliver policies, could bind his principal by an oral contract of insurance, or might waive a policy requirement of written consent of the company to an assignment of the policy, and the company was estopped from denying authority to make such waiver, and especially when such consent was wholly due to acts of the agent and not of the insured. *Collard v. Universal Auto. Ins. Co.*, 55 Idaho 560, 45 P.2d 288 (1935).

Bond.

Bond executed by attorney in fact of foreign surety company under certificate of authority as resident agent was sufficient. *Snyder v. Raymond*, 48 Idaho 810, 285 P. 478 (1930).

Commission for Countersigning Policies.

Where former code § 41-902 (now repealed) prior to 1939 amendment made it unlawful for any foreign insurance company to write a policy of insurance in Idaho, except through a resident licensed agent, who was to countersign all policies, and receive the full commission when premium was paid, widow of deceased insurance agent could not recover commissions on premiums paid on policies placed through a New York brokerage firm on Idaho risk and countersigned by deceased agent for an agreed stipulated rate of \$5 a month, since statute did not prescribe the rate of commission which should be paid the countersigning agent, and no commission was in fact paid anyone; hence court was left without a guide to determine amount of commission. *Broderick v. Travelers Ins. Co.*, 175 F.2d 694 (9th Cir. 1949).

Under the Idaho law, there was nothing to prevent an agent from contracting on the amount of commission that he sees fit to receive for his services, therefore agent's contract to countersign policies of foreign insurer for \$5 per month was lawful. *Broderick v. Travelers Ins. Co.*, 73 F. Supp. 354 (D. Idaho 1947).

§ 41-338. Exceptions to resident agent, countersignature law. — (1) Nothing in [section 41-337, Idaho Code](#), shall be construed as preventing the free and unlimited right to negotiate wholly outside of this state contracts of insurance by licensed nonresident agents or brokers, provided the policies, endorsements or evidence of insurance covering properties or insurable interests in this state are countersigned by a resident agent of this state, in which event the countersigning agent shall receive a commission of not less than five per cent (5%) of the premium paid or one-third (1/3) of the commission paid to the licensed nonresident agent or broker, whichever is less; provided, however, the payment to the countersigning agent shall not exceed the sum of two hundred fifty dollars (\$250) per policy, and when the countersigning commission to be paid is less than five dollars (\$5.00), the countersigning agent may waive any commission due him.

(2) [Section 41-337, Idaho Code](#), shall not apply to the following contracts: (a) Life insurance and annuities; (b) Disability insurance; (c) Title insurance; countersignature of title insurance policies is as provided in [section 41-2702, Idaho Code](#); (d) Policies covering property in transit while in the possession or custody of any common carrier, or the rolling stock or other property of any common carrier used and employed by it as a common carrier of freight or passengers, or both; (e) Reinsurance or retrocessions made by or for authorized insurers; (f) Contracts issued by domestic reciprocal insurers writing workmen's [worker's] compensation for employers commonly known as self-insurers; nor, with respect to countersignature, to policies issued by a reciprocal insurer not using agents compensated by commissions in the general solicitation of business; (g) Bid bonds issued by a surety insurer in connection with any public or private contract; or (h) Ocean marine insurance.

(3) Notwithstanding [section 41-337, Idaho Code](#), and the provisions of subsection (1) of this section, if the law of another state does not require the countersignature of a licensed agent who resides in that state for policies and contracts of insurance or indemnity made, written or placed in that state by a licensed agent who resides in the state of Idaho, the countersignature of a licensed agent who resides in the state of Idaho is not required for

policies and contracts of insurance or indemnity made, written or placed in the state of Idaho by a licensed agent who resides in that other state.

History.

1961, ch. 330, § 101, p. 645; am. 1975, ch. 261, § 1, p. 708; am. 1977, ch. 142, § 3, p. 303; am. 1988, ch. 242, § 1, p. 473.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in paragraph (2)(f) was added by the compiler to reflect the present statutory language of Title 72, Idaho Code.

CASE NOTES

Decisions Under Prior Law Validity of Act.

Former statute making unlawful the sale of any contract of insurance other than life insurance upon persons or property situated in the state, except through a resident agent receiving commissions of not less than 5 per cent, was valid and constitutional. [Ware v. Travelers Ins. Co., 150 F.2d 463 \(9th Cir. 1945\)](#).

§ 41-339. Affidavit of compliance with resident agent, countersignature law. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 102, p. 645, was repealed by S.L. 2005, ch. 75, § 2.

§ 41-340. Retaliatory provision. — (1) The purpose of this section is to aid in the protection of insurers formed under the laws of Idaho and transacting insurance in other states or countries against discriminatory or onerous requirements under the laws of such states or countries or the administration thereof.

(2) When by or pursuant to the laws of any other state or foreign country or province any taxes in the aggregate, are or would be imposed upon Idaho insurers, or upon the agents or representatives of such insurers, which are in excess of such taxes in the aggregate, directly imposed upon similar insurers, or upon the agents or representatives of such insurers, of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes in the aggregate, shall be imposed by the director upon the insurers, or upon the agents or representatives of such insurers, of such other state or country doing business or seeking to do business in Idaho. Any tax imposed by any city, county, or other political subdivision or agency of such other state or country on Idaho insurers or their agents or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(3) When pursuant to the laws of a state, foreign country or province any obligation is or would be imposed upon Idaho insurers or their agents or representatives, in excess of obligations imposed upon similar insurers or their agents or representatives of another state or country, so long as the laws of the state or country imposing the obligation continue in force or are applied, the same obligation may be imposed by the director upon insurers or their agents or representatives of such other states or countries doing business or seeking to do business in Idaho. Any obligation imposed by any city, county, or other political subdivision or agency of another state or country on Idaho insurers or their agents or representatives shall be deemed to be imposed by the other state or country within the meaning of this section. For purposes of this section, the term “obligation” shall mean any license, fee, fine, penalty, deposit requirement or other obligation, prohibition or restriction.

(4) This section shall not apply as to personal income taxes, nor as to ad valorem taxes on real or personal property nor as to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance; except that deductions, from premium taxes or other taxes otherwise payable, allowed on account of real estate or personal property taxes paid shall be taken into consideration by the director in determining the propriety and extent of retaliatory action under this section.

(5) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada, or a province thereof, shall be that state designated by the insurer in writing filed with the director at time of admission to this state or within six (6) months after the effective date of this code, whichever date is the later, and may be any one (1) of the following states:

- (a) That in which the insurer was first authorized to transact insurance;
- (b) That in which is located the insurer's principal place of business in the United States;
- (c) That in which is held the largest deposit of trusteed assets of the insurer for the protection of its policyholders in the United States.

If the insurer makes no such designation its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

(6) The domicile of an insurer formed under the laws of Canada or a province thereof shall be as provided in [section 41-108\(1\), Idaho Code](#).

History.

1961, ch. 330, § 103, p. 645; am. 1997, ch. 354, § 1, p. 1045.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase “the effective date of this code” in the introductory paragraph of subsection (5) refers to the effective date of the insurance code, enacted by S.L. 1961, Chapter 330, effective January 1, 1962.

OPINIONS OF ATTORNEY GENERAL

Constitutionality.

This section does not violate the **commerce clause of the United States Constitution**, as that provision does not apply to the regulation and taxation of insurance. OAG 00-1.

This section would likely survive a challenge under the **equal protection clauses** of the federal or Idaho constitutions, the due process clause of the federal constitution, or the uniformity clause of the Idaho Constitution. OAG 00-1.

§ 41-341. Operational standards between insurer, its parent corporation, subsidiary or affiliated person. — (1) No insurer shall engage directly or indirectly in any transaction or agreement with its parent corporation, or with any subsidiary or affiliated person which shall result or tend to result in:

(a) Substitution through any method of any asset of the insurer with an asset or assets of inferior quality or lower fair market value; or (b) Deception as to the true operating results of the insurer; or

(c) Deception as to the true financial condition of the insurer; or (d) Allocation to the insurer of a proportion of the expense of combined facilities or operations which is unfair and unfavorable to the insurer; or (e) Unfair, unnecessary or excessive charges against the insurer for services, or facilities, or supplies, or reinsurance; or (f) Unfair and inadequate charges by the insurer for reinsurance, services, facilities, or supplies furnished by the insurer to others; or (g) Payment by the insurer for services, facilities, supplies, or reinsurance not reasonably needed by the insurer.

(2) In all transactions between the insurer and its parent corporation, or involving the insurer and any subsidiary or affiliated person, full recognition shall be given to the paramount duty and obligation of the insurer to protect the interests of policyholders, both existing and future.

(3) For the purposes of this section a “subsidiary” is a person of which either the insurer and/or the parent corporation holds practical control, and an “affiliated person” is a person controlled by any combination of the insurer, the parent corporation, a subsidiary, or the principal stockholders or officers or directors of any of the foregoing.

History.

I.C., § 41-341, as added by 1969, ch. 214, § 9, p. 625.

§ 41-342. Redomestication as a domestic insurer — Conversion to foreign insurer. — (1) Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in Idaho in compliance with [section 41-2839, Idaho Code](#). Such a domestic insurer shall be entitled to a certificate of redomestication and a certificate of authority to transact business in this state and shall have the same rights and obligations as other domestic insurers of this state.

(2) Any domestic insurer may, upon the approval of the director, transfer its domicile to any other state in which it is admitted to transact the business of insurance. Upon such a transfer, the insurer shall cease to be a domestic insurer. If the insurer is otherwise qualified, the director shall admit the insurer to this state as a foreign insurer. The director shall approve any such proposed transfer unless he determines that such a transfer is not in the interest of the policyholders of the insurer in this state. After the director has approved the transfer, the director shall provide written notice to the secretary of state that the insurer has transferred its domicile to another state, stating the effective date of the transfer and the state to which the insurer has transferred its domicile. Upon receipt of the written notice from the director and the payment of the fee required in [section 30-21-214, Idaho Code](#), the secretary of state shall file the notice and, on the effective date of the transfer, terminate the existence of the insurance company as a domestic corporation.

(3) The certificate of authority, appointment of statutory agent and licenses, policy forms, rates, authorizations and other filings and approvals in existence at the time an insurer admitted to transact insurance in this state transfers its corporate domicile to this or any other state, continue in effect upon the transfer of corporate domicile. All rates and outstanding policies of any transferring insurer shall remain in full force and effect and policies need not be endorsed as to the new domicile unless so ordered by the director. Every transferring insurer shall either file new policy forms for use

in this state with the director on or before the effective date of the transfer, or use existing policy forms in this state with appropriate endorsements as allowed by and under such conditions as may be approved by the director. Every transferring insurer shall notify the director of the proposed transfer and shall promptly file any resulting amendments to its corporate documents required to be filed with the director.

History.

I.C., § 41-342, as added by 1987, ch. 302, § 1, p. 640; am. 1999, ch. 65, § 4, p. 168; am. 2016, ch. 92, § 1, p. 282; am. 2017, ch. 58, § 22, p. 91.

STATUTORY NOTES

Cross References.

Secretary of state, § 67-901 et seq.

Amendments.

The 2016 amendment, by ch. 92, added “in compliance with [section 41-2839, Idaho Code](#)” at the end of the first sentence in subsection (1).

The 2017 amendment, by ch. 58, substituted “[section 30-21-214, Idaho Code](#)” for “[section 30-1-122, Idaho Code](#)” near the middle of the last sentence in subsection (2).

§ 41-343. Articles of redomestication. — (1) Upon receiving approval under [section 41-342, Idaho Code](#), articles of redomestication shall be executed in duplicate by an insurance corporation by its president or a vice president and by its secretary or an assistant secretary and verified by one (1) of the officers of the corporation and shall set forth:

(a) The date of approval of the director of the Idaho department of insurance of the redomestication; and

(b) The state in which the insurer was originally incorporated, the date the insurer was incorporated in that state, and the date the insurer was authorized to do business as an insurer in the state in which it was originally incorporated.

(2) The insurer shall attach to the articles of redomestication:

(a) Articles of incorporation including such amendments as may be required to comply with the requirements of part 10, chapter 29, title 30, Idaho Code;

(b) A copy of the certificate of redomestication issued by the director of the Idaho department of insurance.

(3) Duplicate originals of the articles of redomestication shall be delivered to the secretary of state. If the secretary of state finds that such articles conform to law, he shall, when all fees have been paid as prescribed in chapter 21, title 30, Idaho Code:

(a) Endorse on each of such duplicate originals the word “Filed,” and the month, day and year of the filing, together with the date from which the insurer has existed and operated as an insurer which shall be the date the insurer was originally incorporated in the state in which the insurer was originally incorporated;

(b) File one (1) of such duplicate originals in his office; and

(c) Issue a certificate of redomestication setting forth the date on which the articles of redomestication were filed and the date from which the insurer has existed and operated as an insurer which shall be the date the

insurer was originally incorporated in the state in which the insurer was originally incorporated.

(4) The certificate of redomestication, together with the duplicate original of the articles of redomestication affixed thereto by the secretary of state, shall be returned to the insurer or to its representative.

History.

I.C., § 41-343, as added by 1987, ch. 302, § 2, p. 640; am. 2017, ch. 58, § 23, p. 91.

STATUTORY NOTES

Cross References.

Secretary of state, § 67-901 et seq.

Amendments.

The 2017 amendment, by ch. 58, substituted “part 10, chapter 29, title 30, Idaho Code” for “[section 30-1-54, Idaho Code](#)” at the end of paragraph (2) (a); and, in subsection (3), substituted “chapter 21, title 30, Idaho Code” for “chapter 1, title 30, Idaho Code” at the end of the introductory paragraph.

§ 41-344. Effective date of redomestication. — A redomestication under [section 41-342, Idaho Code](#), shall become effective upon the issuance of a certificate of redomestication by the secretary of state, or such later date as may be set forth in the notice from the director; provided, however, that an insurer which has redomesticated in the state of Idaho pursuant to [section 41-342, Idaho Code](#), shall be considered to be the same corporation as that corporation which existed under the laws of the state in which it was formerly domiciled and shall be considered as having been an operating insurer from the date that the corporation was authorized to do business as an insurer in its original state of incorporation.

History.

[I.C., § 41-344](#), as added by 1987, ch. 302, § 3, p. 640.

STATUTORY NOTES

Cross References.

Secretary of state, § 67-901 et seq.

§ 41-345. Report. — (1) Every insurer domiciled in this state shall file a report with the director disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements unless such acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements have been submitted to the director for review, approval or information purposes pursuant to other provisions of the insurance code, laws, rules or other requirements.

(2) The report required in subsection (1) of this section is due within fifteen (15) days after the end of the calendar month in which any of the foregoing transactions occur.

(3) One (1) complete copy of the report, including any exhibits or other attachments filed as part thereof, shall be filed with the Idaho department of insurance.

(4) All reports obtained by or disclosed to the director pursuant to [sections 41-345 through 41-347, Idaho Code](#), shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the director, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the director, after giving the insurer who would be affected thereby, notice and an opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the director may publish all or any part thereof in such manner as he may deem appropriate.

History.

[I.C., § 41-345](#), as added by 1995, ch. 68, § 1, p. 173; am. 1999, ch. 65, § 5, p. 168; am. 2004, ch. 310, § 1, p. 871.

STATUTORY NOTES

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (4), see *<http://naic.org>*.

§ 41-346. Acquisitions and dispositions of assets. — (1) Materiality. No acquisitions or dispositions of assets need be reported pursuant to [section 41-345, Idaho Code](#), if the acquisitions or dispositions are not material. For purposes of [sections 41-345 through 41-347, Idaho Code](#), a material acquisition (or the aggregate of any series of related acquisitions during any thirty (30) day period) or disposition (or the aggregate of any series of related dispositions during any thirty (30) day period) is one that is nonrecurring and not in the ordinary course of business and involves more than five percent (5%) of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(2) Scope.

(a) Asset acquisitions subject to [sections 41-345 through 41-347, Idaho Code](#), include every purchase, lease, exchange, merger, consolidation, succession or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

(b) Asset dispositions subject to [sections 41-345 through 41-347, Idaho Code](#), include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction or other disposition.

(3) Information to be reported.

(a) The following information is required to be disclosed in any report of a material acquisition or disposition of assets: (i) Date of the transaction; (ii) Manner of acquisition or disposition; (iii) Description of the assets involved; (iv) Nature and amount of the consideration given or received; (v) Purpose of, or reason for, the transaction; (vi) Manner by which the amount of consideration was determined; (vii) Gain or loss recognized or realized as a result of the transaction; and (viii) Name(s) of the person(s) from whom the assets were acquired or to whom they were disposed.

(b) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated

group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars (\$1,000,000) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

History.

I.C., § 41-346, as added by 1995, ch. 68, § 2, p. 173.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-347. Nonrenewals, cancellations or revisions of ceded reinsurance agreements. — (1) Materiality and scope. No nonrenewals, cancellations or revisions of ceded reinsurance agreements need be reported pursuant to [section 41-345, Idaho Code](#), if the nonrenewals, cancellations or revisions are not material. For purposes of [sections 41-345 through 41-347, Idaho Code](#), a material nonrenewal, cancellation or revision is one that affects:

(a) As respects property-casualty business, including accident and health business written by a property-casualty insurer:

- (i) More than fifty percent (50%) of the insurer's total ceded written premium; or
- (ii) More than fifty percent (50%) of the insurer's total ceded indemnity and loss adjustment reserves.

(b) As respects life, annuity and accident and health business more than fifty percent (50%) of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement.

(c) As respects either property-casualty or life, annuity and accident and health business, either of the following events shall constitute a material revision which must be reported:

- (i) An authorized reinsurer representing more than ten percent (10%) of a total cession is replaced by one (1) or more unauthorized reinsurers; or
- (ii) Previously established collateral requirements have been reduced or waived as respects one (1) or more unauthorized reinsurers representing collectively more than ten percent (10%) of a total cession.

(2) No filing shall be required, however, if:

(a) As respects property-casualty business, including accident and health business written by a property-casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than ten percent

(10%) of it [its] total written premium for direct and assumed business;
or

(b) As respects life, annuity and accident and health business, the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent (10%) of the statutory reserve requirement prior to any cession.

(3) Information to be reported.

(a) The following information is required to be disclosed in any report of a material nonrenewal, cancellation or revision of ceded reinsurance agreements:

- (i) Effective date of the nonrenewal, cancellation or revision;
- (ii) The description of the transaction with an identification of the initiator thereof;
- (iii) Purpose of, or reason for, the transaction; and
- (iv) If applicable, the identity of the replacement reinsurers.

(b) Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars (\$1,000,000) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

History.

I.C., § 41-347, as added by 1995, ch. 68, § 3, p. 173.

STATUTORY NOTES

Compiler's Notes.

The bracketed word “[its]” in paragraph (2)(a) was inserted by the compiler to correct the enacting legislation.

§ 41-348. Prohibited acts — Service providers. — (1) It is unlawful for a person:

(a) Knowing that the payment is for the referral of a claimant to a service provider, either to accept payment from a service provider or, being a service provider, to pay another; or

(b) To provide or claim or represent to have provided services to a claimant, knowing the claimant was referred in violation of paragraph (a) of this subsection.

(2) It is unlawful for a service provider to engage in a regular practice of waiving, rebating, giving, paying, or offering to waive, rebate, give or pay all or part of a claimant's deductible or claim for casualty, disability insurance, worker's compensation insurance, health insurance or property insurance.

(3) As used in this section:

(a) "Health care services" means a service provided to a claimant for treatment of physical or mental illness or injury arising in whole or substantial part from trauma.

(b) "Service provider" means a person who directly or indirectly provides, advertises, or otherwise claims to provide services.

(c) "Services" means health care services, motor vehicle body or other motor vehicle repair and preparing, processing, presenting or negotiating an insurance claim against an insurance company.

(4) Any person or service provider violating the provisions of this section shall be subject to the monetary civil penalties provided in [section 41-327, Idaho Code](#), as if the person or service provider were an insurer.

History.

[I.C., § 41-348](#), as added by 1996, ch. 402, § 1, p. 1335.

§ 41-349. Pharmacy benefit managers. — (1) As used in this section:

(a) “Maximum allowable cost” means the maximum amount that a pharmacy benefit manager will reimburse a pharmacy for the cost of a generic drug.

(b) “Pharmacy benefit manager” means a person or entity doing business in this state that contracts with pharmacies on behalf of an insurer, third-party administrator, or managed care organization to administer prescription drug benefits to residents of this state.

(2) A person may not perform, offer to perform, or advertise any pharmacy benefit management service in this state unless the person is registered as a pharmacy benefit manager with the department of insurance. A person may not utilize the services of another person as a pharmacy benefit manager if the person knows or has reason to know that the other person does not have a registration with the department. Such registration must occur annually no later than April 1 of each year and shall be on a form prescribed by the director. The department may utilize applicable sections of this title to administer registration as provided in this subsection.

(3) A pharmacy benefit manager shall not prohibit a pharmacist or retail pharmacy from providing a covered person information on the amount of the cost share for a prescription drug and the clinical efficacy of a more affordable alternative drug if one is available, and a pharmacy benefit manager may not penalize a pharmacist or retail pharmacy for disclosing such information to a covered person or for selling to a covered person a more affordable alternative if one is available.

(4) A pharmacy benefit manager using maximum allowable cost pricing may place a drug on a maximum allowable cost list if the pharmacy benefit manager does the following:

(a) Ensures that the drug:

(i) 1. Is listed as “A” or “B” rated in the most recent version of the United States food and drug administration’s approved drug products with therapeutic equivalence evaluations, also known as the “orange book”; or

2. Has an “NR” or “NA” rating or a similar rating by a nationally recognized reference; and

(ii) Is available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(b) Provides to a network pharmacy, at the time a contract is entered into or renewed with the network pharmacy, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(c) Reviews and updates maximum allowable cost price information at least once every seven (7) business days to reflect any modification of maximum allowable cost pricing;

(d) Establishes a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(e) Establishes a process by which a network pharmacy, or a network pharmacy’s contracting agent, may appeal the reimbursement for a generic drug no later than thirty (30) days after such reimbursement is made; and

(f) Provides a process for each of its network pharmacies to readily access the maximum allowable cost list specific to that provider.

(5) No pharmacy benefit manager may retroactively deny or reduce a claim for reimbursement of the cost of services after the claim has been adjudicated by the pharmacy benefit manager unless:

(a) The adjudicated claim was submitted fraudulently or improperly; or

(b) The pharmacy benefit manager’s payment on the adjudicated claim was incorrect because the pharmacy or pharmacist had already been paid for the services.

History.

I.C., § 41-349, as added by 2020, ch. 117, § 1, p. 368.

Chapter 4

FEES AND TAXES

Sec.

41-401. Fees — Licenses — Miscellaneous charges.

41-402. Premium tax.

41-402A. Refunds.

41-403. Reduced tax based on Idaho investments. [Repealed.]

41-403A. Notice of intent to claim reduced premium tax rate. [Repealed.]

41-404. Penalty for failure to pay tax.

41-405. Premium tax in lieu of other taxes — Local taxes prohibited.

41-406. Deposit and report of fees, licenses and taxes.

§ 41-401. Fees — Licenses — Miscellaneous charges. — (1) The director shall collect, and persons so served shall pay to the director fees, licenses, and miscellaneous charges as provided for from time to time by rule promulgated by the director. The director may adjust fees, licenses and miscellaneous charges as necessary to allow the department to meet the appropriation as provided for by law.

(2) Any rule setting fees, licenses and miscellaneous charges shall adhere to the Idaho administrative procedure act except that the effective date of such rule shall be July 1 of the calendar year of enactment or change. If the appropriation is not known or set by April 1, the director shall be authorized to use emergency rulemaking procedures to maintain an effective date of July 1.

(3) Insurance Administrative Account:

(a) There is hereby created an account in the dedicated fund in the state treasury, to be designated the “Insurance Administrative Account” to provide for the expenses of the department of insurance as provided for by law.

(b) The insurance administrative account shall be effective December 31, 1984, and be in existence for a period of at least six (6) months prior to the dedicated account appropriation becoming effective and shall consist of the following:

1. All moneys appropriated by the legislature.

2. All fees, licenses and miscellaneous charges collected pursuant to this section.

(c) All moneys placed in the account shall be examined, audited and allowed in the manner now or hereafter provided by law.

(d) Pending use for purposes of the provisions of the laws of this state, moneys in the insurance administrative account shall be invested by the state treasurer in the same manner as provided under [section 67-1210, Idaho Code](#), with respect to other surplus or idle moneys in the state treasury.

(e) At the beginning of each fiscal year, those moneys in the insurance administrative account which exceed the current year's appropriation plus any residual encumbrances made against prior years' appropriations by twenty-five percent (25%) or more shall be transferred to the general account [fund]. The balance in this account shall not be considered excessive until such a transfer is required pursuant to the provisions of this subsection.

History.

I.C., § 41-401, as added by 1984, ch. 23, § 2, p. 38; am. 1993, ch. 124, § 1, p. 315; am. 1998, ch. 225, § 1, p. 773.

STATUTORY NOTES

Cross References.

Idaho administrative procedure act, § 67-5201 et seq.

Prior Laws.

Former § 41-401, which comprised 1961, ch. 330, § 104, p. 645; am. 1969, ch. 214, § 10, p. 625; am. 1972, ch. 369, § 6, p. 1072; am. 1977, ch. 142, § 4, p. 303; am. 1979, ch. 122, § 2, p. 375, was repealed by S.L. 1984, ch. 23, § 1.

Compiler's Notes.

Section 2 of S.L. 1993, ch. 124 read: "There is hereby imposed a one-time only surcharge assessment upon all insurers required to pay premium taxes pursuant to sections 41-401 and 41-402, Idaho Code. Such assessment shall be in an amount equal to three percent (3%) of the tax due for the calendar year 1993. Every insurer shall make a prepayment of the estimated surcharge assessment based upon the preceding calendar year's business and the current year's rate, and shall pay such amount to the director for deposit in the insurance administrative account on or before June 15, 1993. On or before March 1, 1994, any balance of surcharge assessment due shall be paid to the director. Any overpayment of surcharge assessment shall be refunded to the provisions of [section 41-402A, Idaho Code](#)."

The bracketed insertion at the end of the first sentence in paragraph (3)(e) was added by the compiler to correct the name of the referenced fund. See §

67-1205.

Effective Dates.

Section 3 of S.L. 1993, ch. 124 declared an emergency. Approved March 22, 1993.

§ 41-402. Premium tax. — (1) Each authorized insurer, and each formerly authorized insurer with respect to insurance transacted while an authorized insurer, shall file with the director, on or before the dates in each year set forth in subsections (3) and (4) of this section, a statement (on forms as prescribed and furnished by the director) under oath, for the period set forth in subsections (3) and (4) of this section, and pay the director a tax at the rate set forth in subsection (2) of this section, on the following amounts:

(a) As to life insurers, the amount of all gross premiums received by the insurer on direct risks resident in this state, and also, if a domestic insurer, on direct risks resident in any other jurisdiction or jurisdictions in which the insurer is not licensed and upon which no premium tax is otherwise paid or payable, less returned coupons and dividends paid to or credited to policyholders.

(b) As to all insurers other than life insurers, the amount of gross direct premiums written on policies covering subjects of insurance resident, located or performed in this state, and also, if a domestic insurer, on such premiums in any other jurisdiction or jurisdictions in which the insurer is not licensed and upon which no premium tax is otherwise paid or payable, less returned premiums, premiums on policies not taken and dividends paid or credited to policyholders. As to title insurance, “gross premium” means the insurance risk portion of the amount charged for title insurance.

(2) Subject to [section 41-403, Idaho Code](#), as that section applies through calendar year 2009, the rate of tax shall be as follows:

(a) As to title insurance, the rate of tax shall be one and five-tenths percent (1.5%).

(b) As to all other kinds of insurance, the rate of tax shall be:

(i) For calendar year 2004 and before, two and seventy-five hundredths percent (2.75%);

(ii) For calendar year 2005, two and five-tenths percent (2.5%);

- (iii) For calendar year 2006, two and three-tenths percent (2.3%);
- (iv) For calendar year 2007, two and one-tenth percent (2.1%);
- (v) For calendar year 2008, one and nine-tenths percent (1.9%);
- (vi) For calendar year 2009, one and seven-tenths percent (1.7%); and
- (vii) For calendar year 2010 and thereafter, one and five-tenths percent (1.5%).

(3)(a) Every insurer with a tax obligation under this section shall make prepayment of the tax obligations for the current calendar year's business if the sum of the tax obligations for the preceding calendar year's business is four hundred dollars (\$400) or more.

(b) The director shall credit the prepayments toward the appropriate tax obligations of the insurer for the current calendar year.

(c) The minimum amounts of the prepayments shall be percentages of the insurer's tax obligation based on the preceding calendar year's business and the current year's rate and shall be paid to the director's office by the due dates and in the following amounts:

- (i) On or before June 15, sixty percent (60%);
- (ii) On or before September 15, twenty percent (20%); and
- (iii) On or before December 15, fifteen percent (15%).

(4) On or before March 1, any balance of tax due for the preceding calendar year shall be paid to the director.

(5) The effect of transferring policies of insurance from one insurer to another insurer is to transfer the tax prepayment obligation with respect to the policies.

(6) This section shall not apply as to any reciprocal insurer doing exclusively a worker's compensation business and complying with the provisions of the worker's compensation law of this state and writing worker's compensation only for members under that law, if its representatives or agents or the attorney in fact executing such contracts are not compensated on a commission basis.

(7) This section shall not apply as to life insurance policies issued under pension plans or profit-sharing plans exempt or qualified under [section 401\(a\), 403, 404, 408 or 501\(a\) of the Internal Revenue Code](#), as hereafter amended or renumbered from time to time, nor to annuity contracts in general.

(8) This section shall not apply to any reciprocal insurer that exclusively insures members who are governmental entities, as defined by section 6-902(1), (2) and (3), Idaho Code.

(9) Except as otherwise provided in this subsection, this section shall not apply as to any dental care services or as to any dental insurance authorized by title 41, Idaho Code. A tax is hereby imposed upon each contract for dental care services and dental insurance at the rate of four cents (4¢) per contract, per month, such amount to be computed each month. Tax payments shall be made consistent with the documentation requirements and payment dates set forth in this section. The tax imposed in this subsection shall be in lieu of the premium tax provided in this section and in lieu of all other taxes, licenses and fees as provided by [section 41-405, Idaho Code](#); provided however, that this subsection shall not apply to entities governed by chapter 34, title 41, Idaho Code.

(10) The amount of tax due for the current year shall be paid in full in the manner and at the times required in this section without any credit or offset for refunds or other amounts due or claimed to be due by the insurer.

(11) An insurer shall round to the nearest whole dollar any amount shown or required to be shown on any return, form, statement, or other document submitted to the director. Any record or other document prepared or maintained by the director shall express any dollar amount rounded to the nearest whole dollar.

History.

[I.C., § 41-402](#), as added by 1977, ch. 303, § 2, p. 849; am. 1979, ch. 318, § 1, p. 853; am. 1982, ch. 352, § 1, p. 872; am. 1983, ch. 4, § 12, p. 6; am. 1987, ch. 340, § 1, p. 720; am. 1988, ch. 366, § 1, p. 1077; am. 1994, ch. 383, § 1, p. 1229; am. 2001, ch. 111, § 1, p. 400; am. 2004, ch. 356, § 1, p. 1062; am. 2007, ch. 151, § 1, p. 461; am. 2019, ch. 45, § 1, p. 124.

STATUTORY NOTES

Amendments.

The 2019 amendment, by ch. 45, added subsection (11).

Federal References.

Sections 401(a), 403, 404, 408, and 501(a) of the United States Internal Revenue Code, referred to in subsection (7), are codified as 26 U.S.C.S. §§ 401(a), 403, 404, 408, and 501(a).

Compiler's Notes.

Section 41-403, referred to in the introductory paragraph in subsection (2), was repealed by S.L. 2004, ch. 356, § 3, effective January 1, 2010.

The words enclosed in parentheses so appeared in the law as enacted.

Amendments.

The 2007 amendment, by ch. 151, added subsection (9) and redesignated former subsection (9) as (10).

Effective Dates.

Section 4 of S.L. 1994, ch. 383 provided that this act shall be in full force and effect on and after January 1, 1995.

Section 4 of S.L. 2004, ch. 356, provided: "Sections 1 and 2 of this act shall be in full force and effect on and after July 1, 2004. Section 3 of this act shall be in full force and effect on and after January 1, 2010."

OPINIONS OF ATTORNEY GENERAL**Constitutionality.**

This section does not violate the commerce clause of the United States Constitution, as that provision does not apply to the regulation and taxation of insurance. OAG 00-1.

This section does not violate the equal protection clauses of the federal or Idaho constitutions, the due process clause of the federal constitution, or the uniformity clause of the Idaho Constitution. OAG 00-1.

§ 41-402A. Refunds. — Where there has been an overpayment of any taxes, fines or penalties due under this chapter, the director is authorized to refund all such taxes, fines or penalties erroneously or illegally collected or paid. No such refund shall be paid after one (1) year from the due date of the statement required in [section 41-402\(4\), Idaho Code](#), unless before the expiration of such period a written claim is filed therefore [therefor] by the insurer on such forms and in such manner as is prescribed by the director.

History.

[I.C., § 41-402A](#), as added by 1987, ch. 340, § 2, p. 720.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of the section was added by the compiler to correct the enacting legislation.

§ 41-403. Reduced tax based on Idaho investments. [Repealed.]

Repealed by S.L. 2004, ch. 356, § 3, effective January 1, 2010.

History.

1961, ch. 330, § 106, p. 645; am. 1969, ch. 214, § 12, p. 625; am. 1970, ch. 237, § 1, p. 653; am. 1974, ch. 246, § 1, p. 1622; am. 1977, ch. 303, § 3, p. 849; am. 1983, ch. 185, § 1, p. 500; am. 1985, ch. 230, § 1, p. 550; am. 1987, ch. 340, § 3, p. 720; am. 1988, ch. 366, § 2, p. 1077; am. 1994, ch. 383, § 2, p. 1229; am. 2000, ch. 183, § 1, p. 452; am. 2004, ch. 356, § 2, p. 1062.

**§ 41-403A. Notice of intent to claim reduced premium tax rate.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-403A, as added by 1987, ch. 340, § 4, p. 720, was repealed by S.L. 1988, ch. 366, § 3.

§ 41-404. Penalty for failure to pay tax. — Any insurer failing to render the statement and pay the tax required under [section 41-402, Idaho Code](#), on or before the date due, including any extension of time granted by the director pursuant to [section 41-335\(1\), Idaho Code](#), shall be liable to a fine of twenty-five dollars (\$25.00) for each additional day of delinquency; and the taxes may be collected by distraint and recovered by an action to be instituted by the attorney general in the name of the state in any court of competent jurisdiction. The director shall suspend or revoke the certificate of authority of the delinquent insurer until the statement is filed and the taxes and fine, if any, are fully paid.

History.

1961, ch. 330, § 107, p. 645; am. 1969, ch. 214, § 13, p. 625; am. 1988, ch. 366, § 7, p. 1077.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 8 of S.L. 1988, ch. 366 read: “An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2, 3, 5, 6 and 7 of this act shall be in full force and effect on and after passage and approval, and retroactively to January 1, 1988; and Section 4 of this act shall be in full force and effect on and after passage and approval, and retroactively to January 1, 1987.” Approved April 6, 1988.

§ 41-405. Premium tax in lieu of other taxes — Local taxes prohibited. — (1) Payment to the director by an insurer of the tax upon its premiums as in this chapter required, shall be in lieu of all other taxes upon premiums, taxes upon income, franchise or other taxes measured by income, and upon the personal property of the insurer and the shares of stock or assets thereof; provided, that all real property, if any, of the insurer shall be listed, assessed and taxed the same as real property of like character of individuals.

(2) The state of Idaho hereby preempts the field of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses and fees upon insurers and their agents and other representatives as such; and no county, city, municipality, district, or other political subdivision or agency in this state shall levy upon insurers, or upon their agents and representatives as such, any such tax, license or fee; nor shall any such county, city, municipality, district, political subdivision or agency require of any such insurer, agent or representative, duly authorized or licensed as such under this code, any additional authorization, license, or permit of any kind for conducting therein transactions otherwise lawful under the authority or license granted under this code.

History.

1961, ch. 330, § 108, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3. (See § 41-203).

CASE NOTES

Purpose.

Taxes preempted.

Purpose.

The legislative purpose in enacting this section was to extend the full protection of state preemption from “insurers” to “their agents and other representatives as such.” *First Am. Title Co. v. Clark*, 99 Idaho 10, 576 P.2d 581 (1978).

Taxes Preempted.

Since a county tax on the “title plant” of a title insurance company is, in reality, a tax on the company’s privilege of doing business, such tax is preempted by the state and may not be assessed and collected by county governments. *First Am. Title Co. v. Clark*, 99 Idaho 10, 576 P.2d 581 (1978).

Cited *AIA Servs. Corp. v. Idaho State Tax Comm’n*, 136 Idaho 184, 30 P.3d 962 (2001).

§ 41-406. Deposit and report of fees, licenses and taxes. — (1) The director shall transmit all taxes, fines and penalties collected by him to the state treasurer as provided under [section 59-1014, Idaho Code](#). The director shall file with the state controller a statement of each deposit thus made. All such funds received shall be deposited into the department of insurance suspense account.

Such funds shall be distributed as follows:

(a) The director may deposit up to twenty percent (20%) of the funds received in the insurance refund account which is hereby created for the purpose of repaying overpayments of any taxes, fines, and penalties or other erroneous receipts. There is hereby appropriated out of the insurance refund account so much thereof as shall be necessary for the payment of refunds. Any unencumbered balance remaining in the insurance refund account on June 30 of each and every year in excess of forty thousand dollars (\$40,000) shall be transferred to the general fund and the state controller is hereby authorized and directed on such dates to make such transfers unless the board of examiners, which is hereby authorized to do so, changes the date of transfer or sum to be transferred.

(b) That portion of the premium tax, payable to the public employee retirement fund as provided in [section 59-1394, Idaho Code](#), shall be distributed to that fund.

(c) That portion of the premium tax necessary to cover administrative costs incurred by the department in placing insurance companies or any other insurance entities into receivership or under administrative supervision, and such costs cannot be satisfied from the assets of these companies or entities, shall be distributed to the insurance insolvency administrative fund which is hereby created. There is hereby appropriated out of the insurance insolvency administrative fund so much thereof as shall be necessary, but not to exceed two hundred thousand dollars (\$200,000) in any one (1) fiscal year, for the payment of the department's administrative expenses incurred in carrying out such receiverships or supervision. A balance of one hundred thousand dollars (\$100,000) shall be maintained in this fund on June 30 of each year.

(d) After all other deductions authorized in this section have been made, if the premium tax remaining exceeds forty-five million dollars (\$45,000,000), one-fourth ($\frac{1}{4}$) of such excess is hereby appropriated and shall be paid to the Idaho individual high risk reinsurance pool established in chapter 55, title 41, Idaho Code.

(e) The balance of the premium tax, fines and penalties shall be distributed to the general fund of the state of Idaho.

(f) All moneys received for fees, licenses and miscellaneous charges collected shall be distributed to the insurance administrative account.

(2) The director shall make and file with the state controller an itemized statement of the fees, licenses, taxes, fines and penalties collected by him during the preceding month.

History.

I.C., § 41-406, as added by 1984, ch. 23, § 3, p. 38; am. 1987, ch. 340, § 5, p. 720; am. 1993, ch. 118, § 1, p. 295; am. 1994, ch. 180, § 82, p. 420; am. 2000, ch. 64, § 1, p. 144; am. 2000, ch. 472, § 18, p. 1602; am. 2003, ch. 308, § 8, p. 844; am. 2012, ch. 158, § 1, p. 433; am. 2013, ch. 90, § 1, p. 221; am. 2016, ch. 361, § 1, p. 1067.

STATUTORY NOTES

Cross References.

Board of examiners, Idaho Const., Art. IV, § 18 and § 67-2001 et seq.

General fund, § 67-1205.

Insurance administrative account, § 41-401.

State controller, § 67-1001 et seq.

State treasurer, § 67-1201 et seq.

Suspense accounts, § 67-1209.

Amendments.

This section was amended by two 2000 acts which appear to be compatible and have been compiled together.

The 2000 amendment, by ch. 64, § 1, at the beginning of subdivision (1) (a), substituted “The director may deposit up to twenty percent (20%) of the funds received” for “Ten percent (10%) shall be deposited”.

The 2000 amendment, by ch. 472, § 18, substituted “fund” for “account” throughout the section; in subdivision (1)(c), in the next-to-last sentence, substituted “supervision” for “supervisions”; added present subdivision (1) (d); redesignated former subdivisions (1)(d) and (1)(e) as present subdivisions (1)(e) and (1)(f).

The 2012 amendment, by ch. 158, deleted “and shall deliver a certified copy of the statement to the state treasurer” from the end of subsection (2).

The 2013 amendment, by ch. 90, deleted “with eighty percent (80%) of such moneys to be appropriated to the CHIP Plan B subaccount and the children’s access card program subaccount and twenty percent (20%) of such moneys, not to exceed one million two hundred thousand dollars (\$1,200,000) per year, to be appropriated to the small business health insurance pilot program subaccount” from the ending of paragraph (1)(d).

The 2016 amendment, by ch. 361, added paragraph (1)(d), which had previously been null and void.

Compiler’s Notes.

Section 2 of S.L. 2013, ch. 90 provided: “The provisions of subsection (1)(d) of Section 1 of this act shall be null, void and of no force and effect on and after October 1, 2015.” Paragraph (1)(d) was readded to this section by S.L. 2016, ch. 361, § 1, effective July 1, 2016.

Effective Dates.

Section 2 of S.L. 1993, ch. 118 declared an emergency. Approved March 22, 1993.

Section 241 of S.L. 1994, ch. 180 provided that such act should become effective on and after the first Monday in January, 1995 [January 2, 1995] if the amendment to the Constitution of Idaho changing the name of the state auditor to state controller [1994 S.J.R. No. 109, p. 1493] was adopted at the general election held on November 8, 1994. Since such amendment was adopted, the amendment to this section by § 77 of S.L. 1994, ch. 180 became effective January 2, 1995.

Section 2 of S.L. 2000, ch. 64 declared an emergency. Approved March 29, 2000.

Section 2 of S.L. 2016, ch. 361 provided that the act should take effect on and after July 1, 2017.

Chapter 5
KINDS OF INSURANCE — LIMITS OF RISK —
REINSURANCE

Sec.

41-501. Definitions not mutually exclusive.

41-502. “Life insurance” defined.

41-503. “Disability insurance” defined.

41-504. “Property insurance” defined.

41-505. “Marine and transportation insurance” defined.

41-506. “Casualty insurance” defined.

41-507. “Surety insurance” defined.

41-508. “Title insurance” defined.

41-509. Limit of risk.

41-510. “Reinsurance” defined.

41-511. Authorized reinsurance.

41-512. Reinsurance by impaired or withdrawing insurers — Penalty for violation.

41-513. “Share and deposit insurance” defined.

41-514. Purpose.

41-515. Credit for reinsurance.

41-516. Individual or group accident and sickness insurance defined.

§ 41-501. Definitions not mutually exclusive. — It is intended that certain insurance coverages may come within the definitions of two (2) or more kinds of insurance as defined in this chapter, and the inclusion of such coverage within one (1) definition shall not exclude it as to any other kind of insurance within the definition of which such coverage is likewise reasonably includable.

History.

1961, ch. 330, § 110, p. 645.

§ 41-502. “Life insurance” defined. — “Life insurance” is insurance on human lives. The transaction of life insurance includes also the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured’s disability, and optional modes of settlement of proceeds of life insurance. Life insurance does not include workmen’s [worker’s] compensation coverages.

History.

1961, ch. 330, § 111, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertion in the last sentence was added by the compiler to reflect the present statutory language in Title 72, Idaho Code.

§ 41-503. “Disability insurance” defined. — (1) “Disability insurance” includes:

(a) Insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Disability insurance does not include worker’s compensation coverages; and (b) A managed care plan for which a certificate of authority is required pursuant to chapter 39, title 41, Idaho Code.

History.

1961, ch. 330, § 112, p. 645; am. 1997, ch. 204, § 36, p. 579.

STATUTORY NOTES

Compiler’s Notes.

As amended by S.L. 1997, ch. 204, § 36, this section contained no subsection (2).

§ 41-504. “Property insurance” defined. — “Property insurance” is insurance on real or personal property of every kind and of every interest therein, whether on land, water, or in the air, against loss or damage from any and all hazard or cause, and against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage. Property insurance does not include title insurance, as defined in section 41-508[, Idaho Code].

History.

1961, ch. 330, § 113, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertion at the end of the section was added by the compiler to conform to the statutory citation style.

§ 41-505. “Marine and transportation insurance” defined. — “Marine and transportation insurance” includes:

(1) Insurance against any kind of loss or damage to: (a) Vessels, craft, aircraft, cars, automobiles and vehicles of every kind, as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment, or reshipment incident thereto, including marine builder’s risks and all personal property floater risks, and (b) Person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance or use of the subject matter of such insurance (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles), and (c) Precious stones, jewels, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise, and (d) Bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion are the only hazards to be covered; piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion; other aids to navigation and transportation, including dry docks and marine railways, against all risks.

(2) “Marine protection and indemnity insurance,” meaning insurance against, or against legal liability of the insured for, loss, damage or expense arising out of, or incident to, the ownership, operation, chartering,

maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person.

History.

1961, ch. 330, § 114, p. 645.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-506. “Casualty insurance” defined. — (1) “Casualty insurance” includes:

(a) Vehicle insurance. Insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability or expense resulting from or incidental to ownership, maintenance or use of any such vehicle, aircraft or animal; and provision of medical, hospital, surgical, disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries, or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to insurance on the vehicle, aircraft or animal.

(b) Automobile guaranty. Insurance of the mechanical condition, or freedom from defective or worn parts or equipment, of motor vehicles.

(c) Liability insurance. Insurance against legal liability for the death, injury, or disability of any human being, or for damage to property; and provision of medical, hospital, surgical, disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance.

(d) Workmen’s [Worker’s] compensation. Insurance of the obligations accepted by, imposed upon, or assumed by employers under law for death, disablement, or injury of employees.

(e) Burglary and theft. Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, or wrongful conversion, disposal, or concealment, or from any attempt at any of the foregoing; including supplemental coverage for medical, hospital, surgical, and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery, or theft by another; also insurance

against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances, or any other valuable papers and documents, resulting from any cause.

(f) Personal property floater. Insurance upon personal effects against loss or damage from any cause, under a personal property floater.

(g) Glass. Insurance against loss or damage to glass, including its lettering, ornamentation, and fittings.

(h) Boiler and machinery. Insurance against any liability and loss or damage to property or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus, and to make inspection of and issue certificates of inspection upon boilers, machinery, and apparatus of any kind, whether or not insured.

(i) Leakage and fire extinguishing equipment. Insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus, water pipes or containers, or by water entering through leaks or openings in buildings, and insurance against loss or damage to such sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus.

(j) Credit. Insurance against loss or damage resulting from failure of debtors to pay their obligations to the insured.

(k) Malpractice. Insurance against legal liability of the insured, and against loss, damage, or expense incidental to a claim of such liability, and including medical, hospital, surgical, and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death, injury or disablement of any person, or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary, or professional service.

(l) Congenital defects. Insurance against congenital defects in human beings.

(m) Livestock. Insurance against loss or damage to livestock, and services of a veterinary for such animals.

(n) Elevator. Insurance against loss of or damage to any property of the insured, resulting from the ownership, maintenance or use of elevators, except loss or damage by fire, and to make inspections of and issue certificates of inspection upon, elevators.

(o) Entertainments. Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event, or exhibition against loss from interruption, postponement, or cancellation thereof due to death, accidental injury, or sickness of performers, participants, directors, or other principals.

(p) Failure to file certain instruments. Insurance against loss resulting from failure to file or record written instruments affecting the title of or creating a lien upon personal property.

(q) Miscellaneous. Miscellaneous casualty insurance shall include, but not be limited to, credit unemployment insurance indemnifying a debtor for installment or other periodic payments on the indebtedness while a debtor suffers a loss of income due to involuntary unemployment. Insurance against any other kind of loss, damage, or liability properly a subject of insurance and not within any other kind of insurance as defined in this chapter, if such insurance is not disapproved by the director as being contrary to law or public policy.

(2) Provision of medical, hospital, surgical, and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under subdivisions (a) (vehicle), (c) (liability), (e) (burglary), and (k) (malpractice) of subsection (1) shall for all purposes be deemed to be the same kind of insurance to which it is so incidental, and shall not be subject to provisions of this code applicable to life or disability insurances.

History.

1961, ch. 330, § 115, p. 645; am. 1979, ch. 314, § 1, p. 846.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in paragraph (1)(d) was added by the compiler to conform to the present language of Title 72, Idaho Code.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-507. “Surety insurance” defined. — “Surety insurance” includes:

(1) Fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust.

(2) Insurance or guaranty of the obligations of employers under workmen’s [worker’s] compensation laws.

(3) Insurance guaranteeing the performance of contracts, other than insurance policies, and guaranteeing and executing bonds, undertakings, and contracts of suretyship.

(4) Insurance indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss, resulting from any cause, of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts or other valuable papers, documents, money, precious metals and articles made therefrom, jewelry, watches, necklaces, bracelets, gems, precious and semiprecious stones, including any loss while the same are being transported in armored motor vehicles, or by messenger, but not including any other risks of transportation or navigation; also insurance against loss or damage to such an insured’s premises or to his furniture, furnishings, fixtures, equipment, safes, and vaults therein, caused by burglary, robbery, theft, vandalism or malicious mischief, or any attempt thereat.

History.

1961, ch. 330, § 116, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertion in subsection (2) was added by the compiler to reflect the present statutory language in Title 72, Idaho Code.

§ 41-508. “Title insurance” defined. — (1) “Title insurance” is the certification or guarantee of title or ownership, or insurance of owners of property or others having an interest therein or liens or encumbrances thereon, against loss by encumbrance, or defective titles, or invalidity, or adverse claim to title. This definition shall not be deemed to apply as to the business of preparing and issuing abstracts of, but not certifying, guaranteeing, or insuring, title to or ownership of property or certifying to the validity of documents relative to such title.

(2) A title insurer may also insure: (a) The identity, due execution, and validity of any note or bond secured by mortgage or deed of trust; and (b) The identity, due execution, validity and recording of any such mortgage or deed of trust.

History.

1961, ch. 330, § 117, p. 645.

§ 41-509. Limit of risk. — (1) No insurer shall retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding ten percent (10%) of its surplus to policyholders.

(2) A “subject of insurance” for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake and other catastrophic hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of any other hazard insured against.

(3) Reinsurance ceded as authorized by [section 41-511, Idaho Code](#) shall be deducted in determining risk retained. As to surety risks, deduction shall also be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety’s consent and for the surety’s protection.

(4) As to alien insurers, this section shall relate only to risks and surplus to policyholders of the insurer’s United States branch.

(5) “Surplus to policyholders” for the purposes of this section, in addition to the insurer’s capital and surplus, shall be deemed to include any voluntary reserves which are not required pursuant to law, and shall be determined from the last sworn statement of the insurer on file with the director, or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(6) This section shall not apply to life or disability insurance, annuities, title insurance, insurance of wet marine and transportation risks, worker’s compensation insurance, employers’ liability coverages, nor to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

History.

1961, ch. 330, § 118, p. 645; am. 2007, ch. 280, § 1, p. 811.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Amendments.

The 2007 amendment, by ch. 280, in subsection (6), substituted “worker’s compensation” for “workmen’s compensation”; and deleted subsection (7), which read: “Limits of risks as to newly formed domestic mutual insurers shall be as provided in section 41-2820.”

§ 41-510. “Reinsurance” defined. — “Reinsurance” is a contract under which an originating insurer (called the “ceding” insurer) procures insurance for itself in another insurer (called the “assuming” insurer or the “reinsurer”) with respect to part or all of an insurance risk of the originating insurer.

History.

1961, ch. 330, § 119, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-511. Authorized reinsurance. — (1) An insurer may accept reinsurance only of such risks, and retain risk thereon within such limits, as it is otherwise authorized to insure.

(2) Except as provided in sections 41-512, 41-2856 (mergers and consolidations of stock insurers) and 41-2858, Idaho Code (bulk reinsurance, mutual insurers), an insurer may reinsure all or any part of any particular Idaho risk with an insurer authorized to transact such insurance in this state, or in any other solvent insurer approved or accepted by the director for the purpose of such reinsurance. The director shall not so approve or accept any such reinsurance by a ceding domestic insurer in an unauthorized insurer which he finds for good cause would be contrary to the interests of the policy holders or stockholders of such domestic insurer. The director shall not so approve any foreign reinsurer that possesses surplus as to policy holders in an amount less than that required under [section 41-313, Idaho Code](#), of a foreign stock insurer authorized to transact in this state the same kind or kinds of insurance as that ceded.

(3) Upon request of the director, a ceding insurer shall promptly inform the director in writing of the cancellation or any other material change of any of its reinsurance treaties or arrangements.

(4) This section does not apply to marine and transportation insurance.

History.

1961, ch. 330, § 120, p. 645; 1974, ch. 210, § 1, p. 1547; am. 1991, ch. 276, § 2, p. 712.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer. 87 A.L.R.6th 319.

§ 41-512. Reinsurance by impaired or withdrawing insurers — Penalty for violation. — (1) No authorized insurer whose capital stock (if a stock insurer) or required minimum surplus (if a mutual or reciprocal insurer) is impaired, or which is insolvent, or which is withdrawing from business in this state, shall reinsure its insurance in force on Idaho risks with any insurer not authorized to transact such insurance in this state, until the plan of such reinsurance has been submitted to the director and has been approved by him in writing.

(2) The director shall approve such plan of reinsurance unless he finds that one or more of the following grounds for disapproval exist:

- (a) The proposed reinsurer is in unsound financial condition; or
- (b) The proposed reinsurance would not provide the Idaho policy holders involved, with reasonably adequate service; or
- (c) The proposed reinsurer could not qualify for a certificate of authority to transact such insurance in this state; or
- (d) The proposed reinsurance would be contrary to the interests of such Idaho policy holders.

(3) No domestic insurer shall accept reinsurance of all or substantially all of the risks of another insurer unless the plan for such reinsurance has been submitted to and approved by the director, as provided in sections 41-2856 (mergers and consolidations of stock insurers) and 41-2858[, Idaho Code] (bulk reinsurance, mutual insurers).

(4) Upon effectuation of any such reinsurance the reinsurer shall become liable to the insured under the policy for any loss occurring under the policy so reinsured, and shall, within a reasonable time after such effectuation, replace such policies with its own policies, or by endorsement on the original policies acknowledge liability thereunder. In the case of cancellation of such a policy after effectuation of the reinsurance, the reinsurer shall be liable to the insured thereunder for the return premium due.

(5) Any person who acts for, or purports to act for, any insurer or reinsurer in violating any of the provisions of this section shall be guilty of a felony and, upon conviction, shall be punished by a fine of not exceeding ten thousand dollars (\$10,000) or by imprisonment in the penitentiary for not exceeding ten (10) years, or by both such fine and imprisonment.

History.

1961, ch. 330, § 121, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of subsection (3) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer. 87 A.L.R.6th 319.

§ 41-513. “Share and deposit insurance” defined. — Share and deposit insurance is that form of contract which guarantees the redemption of shares and deposits in a bank or a savings and loan association to its account holders and/or which guarantees to members of credit unions the redemption of shares, share accounts and deposits in a credit union.

History.

I.C., § 41-513, as added by 1983, ch. 177, § 3, p. 484.

§ 41-514. Purpose. — The purpose of sections 41-514 and 41-515, Idaho Code, is to protect the interest of insureds, claimants, ceding insurers, assuming insurers and the public generally. The legislature hereby declares its intent to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the legislature hereby provides a mandate that upon the insolvency of a non-United States insurer or reinsurer that provides security to fund its United States obligations in accordance with this chapter, the assets representing the security shall be maintained in the United States, and claims shall be filed with and valued by the state insurance director with regulatory oversight, and the assets shall be distributed, in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The legislature declares that the matters contained in this chapter are fundamental to the business of insurance in accordance with [15 U.S.C. 1011](#) and [1012](#).

History.

[I.C., § 41-514](#), as added by 2017, ch. 76, § 1, p. 197.

STATUTORY NOTES

Compiler's Notes.

Former § 41-514 was amended and redesignated as § 41-515 by S.L. 2017, ch. 76, § 2, effective July 1, 2017.

§ 41-515. Credit for reinsurance. — (1) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (a), (b), (c), (d), (e) or (f) of subsection (2) of this section; provided further, that the director may adopt by rule pursuant to subsection (5)(a) of this section specific additional requirements relating to or setting forth:

- (a) The valuation of assets or reserve credits;
- (b) The amount and forms of security supporting reinsurance arrangements described in subsection (5)(a) of this section; and
- (c) The circumstances pursuant to which credit will be reduced or eliminated.

(2) Credit shall be allowed under paragraph (a), (b), or (c) of this subsection only, as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under paragraph (c) or (d) of this subsection only if the applicable requirements of paragraph (g) of this subsection have been satisfied.

- (a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.
- (b) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the director as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer must:
 - (i) File with the director evidence of its submission to this state's jurisdiction;
 - (ii) Submit to this state's authority to examine its books and records;
 - (iii) Be licensed to transact insurance or reinsurance in at least one (1) state or, in the case of a United States branch of an alien assuming

insurer, be entered through and licensed to transact insurance or reinsurance in at least one (1) state;

(iv) File annually with the director a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(v) Demonstrate to the satisfaction of the director that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than twenty million dollars (\$20,000,000) and its accreditation has not been denied by the director within ninety (90) days after submission of its application.

(c) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:

(i) Maintains a surplus as regards policyholders in an amount not less than twenty million dollars (\$20,000,000); and

(ii) Submits to the authority of this state to examine its books and records.

The requirement of subparagraph (i) of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(d)(i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in subsection (4)(b) of this section for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the director information substantially the same as that required to be reported on the national association of insurance commissioners (NAIC) annual

statement form by licensed insurers to enable the director to determine the sufficiency of the trust fund. The assuming insurer shall submit to examination of its books and records by the director and bear the expense of examination.

(ii) Credit for reinsurance shall not be granted under this paragraph, unless the form of the trust and any amendments to the trust have been approved by:

1. The director of the state where the trust is domiciled; or
2. The director of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

The form of the trust and any trust amendments also shall be filed with the director of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the director. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustees of the trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year-end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(iii) The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and, in addition, the assuming insurer shall maintain a trustee

surplus of not less than twenty million dollars (\$20,000,000), except as provided in subparagraph (iii)2. of this paragraph.

2. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) full years, the director with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors including, when applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

3. In the case of a group that includes incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust shall consist of a trustee account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group;

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, the trust shall consist of a trustee account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(C) In addition to these trusts, the group shall maintain in trust a trustee surplus of which one hundred million dollars

(\$100,000,000) shall be held jointly for the benefit of United States ceding insurers of any member of the group for all years of the account.

The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if certification is unavailable, financial statements prepared by independent public accountants of each underwriter member of the group.

(iv) In the case of a group of incorporated underwriters under common administration, the group shall:

1. Have continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation;
2. Maintain aggregate policyholders' surplus of ten billion dollars (\$10,000,000,000);
3. Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;
4. Maintain a joint trusteed surplus of which one hundred million dollars (\$100,000,000) shall be held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and
5. Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the director an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial

statements of each underwriter member of the group prepared by its independent public accountant.

(e) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the director as a reinsurer in this state and has secured its obligations in accordance with the following requirements:

(i) In order to be eligible for certification, the assuming insurer must:

1. Be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the director pursuant to subparagraph (iii) of this paragraph;
2. Maintain minimum capital and surplus, or the equivalent, in an amount to be determined by the director pursuant to rule;
3. Maintain financial strength ratings from two (2) or more rating agencies deemed acceptable by the director pursuant to rule;
4. Agree to submit to the jurisdiction of this state, appoint the director as its agent for service of process in this state and agree to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;
5. Agree to meet applicable information filing requirements as determined by the director, both with respect to an initial application for certification and on an ongoing basis; and
6. Satisfy any other requirements for certification deemed relevant by the director.

(ii) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying the requirements of subparagraph (i) of this paragraph:

1. The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation

of the association or any of its members, in an amount determined by the director to provide adequate protection;

2. The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

3. Within ninety (90) days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the director an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(iii) The director shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the director as a certified reinsurer.

1. In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the director shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the director with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the director has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the director.

2. A list of qualified jurisdictions shall be published through the NAIC committee process. The director shall consider this list in

determining qualified jurisdictions. If the director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the director shall provide thoroughly documented justification in accordance with criteria to be developed under rulemaking.

3. United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

4. If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the director has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(iv) The director shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the director pursuant to rulemaking. The director shall publish a list of all certified reinsurers and their ratings.

(v) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with its rating, as specified in rulemaking promulgated by the director.

1. In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the director and consistent with the provisions of subsection (3) of this section, or in a multibeneficiary trust in accordance with paragraph (d) of this subsection, except as otherwise provided in this paragraph.

2. If a certified reinsurer maintains a trust to fully secure its obligations subject to paragraph (d) of this subsection and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this paragraph or comparable laws of other United States jurisdictions and for its obligations subject to

paragraph (d) of this subsection. It shall be a condition to the grant of certification under this paragraph that the certified reinsurer shall have bound itself by the language of the trust and agreement with the director with principal regulatory oversight of each such trust account to fund, upon termination of any such trust account, out of the remaining surplus of such trust, any deficiency of any other such trust account.

3. The minimum trustee surplus requirements provided in paragraph (d) of this subsection are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this paragraph, except that such trust shall maintain a minimum trustee surplus of ten million dollars (\$10,000,000).

4. With respect to obligations incurred by a certified reinsurer under this subparagraph, if the security is insufficient, the director shall reduce the allowable credit by an amount proportionate to the deficiency and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

5. For purposes of this subparagraph, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent (100%) of its obligations. As used here, the term "terminated" refers to revocation, suspension, voluntary surrender and inactive status. If the director continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(vi) If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the director has the discretion to defer to that jurisdiction's certification and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

(vii) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order

to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of subparagraph (v) of this paragraph, and the director shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(f) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), (b), (c), (d) or (e) of this subsection, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by applicable law or regulation of that jurisdiction.

(g) If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the credit permitted in paragraphs (c) and (d) of this subsection shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(i) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or of any appellate court in the event of an appeal; and

(ii) To designate the director or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company.

This provision is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

(h) If the assuming insurer does not meet the requirements of paragraph (a), (b) or (c) of this subsection, the credit permitted by paragraph (d) or (e) of this subsection shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(i) If the trust fund is inadequate because it contains an amount less than the amount required by paragraph (d)(iii) of this subsection, or if

the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the director with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the director with regulatory oversight all of the assets of the trust fund.

(ii) The assets shall be distributed by, and claims shall be filed with and valued by, the director with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(iii) If the director with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the director with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(iv) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

(i) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the director may suspend or revoke the reinsurer's accreditation or certification.

(i) The director must give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the director's order on hearing, unless:

1. The reinsurer waives its right to hearing;
2. The director's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under paragraph (e)(vi) of this subsection; or
3. The director finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the director's

order.

(ii) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit, except to the extent that the reinsurer's obligations under the contract are secured in accordance with subsection (3) of this section. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation, except to the extent that the reinsurer's obligations under the contract are secured in accordance with paragraph (e)(v) of this subsection or with subsection (3) of this section.

(j) The following provisions apply regarding the concentration of risk:

(i) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the director within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(ii) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the director within thirty (30) days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(3) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements in subsection (2) of this section shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer; provided further, that the

director may adopt by rule pursuant to subsection (5)(a) of this section specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection (5)(a) of this section, and the circumstances pursuant to which credit will be reduced or eliminated. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution as defined in subsection (4)(b) of this section. This security may be in the form of:

(a) Cash;

(b) Securities listed by the securities valuation office of the NAIC, including those deemed exempt from filing as defined by the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;

(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution as defined in subsection (4)(a) of this section no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(d) Any other form of security acceptable to the director.

(4)(a) For purposes of subsection (3)(c) of this section a "qualified United States financial institution" means an institution that:

(i) Is organized or (in the case of a United States office of a foreign banking organization) licensed, under the laws of the United States or

any state thereof;

(ii) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(iii) Has been determined by either the director or the securities valuation office of the NAIC, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the director.

(b) A “qualified United States financial institution” means, for purposes of the provisions of this statute specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(i) Is an organization, or (in the case of a United States branch or agency office of a foreign banking organization) licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(ii) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

(5) The director may adopt rules implementing the provisions of this chapter.

(a) The director is further authorized to adopt rules applicable to reinsurance arrangements described in subparagraph (i) of this paragraph.

(i) A rule adopted pursuant to this subparagraph may apply only to reinsurance relating to: life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits; universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period; variable annuities with guaranteed death or living benefits; long-term care insurance policies; or such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(ii) A rule adopted pursuant to subparagraph (i) of this paragraph concerning life insurance policies with guaranteed nonlevel gross

premiums or guaranteed nonlevel benefits or universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period may apply to any treaty containing policies issued on or after January 1, 2015, and policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(iii) A rule adopted pursuant to this paragraph may require the ceding insurer, in calculating the amounts or forms of security required to be held under rules promulgated under this authority, to use the valuation manual referenced in [section 41-612, Idaho Code](#).

(iv) A rule adopted pursuant to this paragraph shall not apply to cessions to an assuming insurer that:

1. Is certified in this state or, if this state has not adopted provisions substantially equivalent to subsection (2)(e) of this section, certified in a minimum of five (5) other states; or

2. Maintains at least two hundred fifty million dollars (\$250,000,000) in capital and surplus when determined in accordance with the NAIC accounting practices and procedures manual, referenced in [section 41-335, Idaho Code](#), and is:

- (A) Licensed in at least twenty-six (26) states; or

- (B) Licensed in at least ten (10) states, and licensed or accredited in a total of at least thirty-five (35) states.

(b) The authority to adopt rules pursuant to paragraph (a) of this subsection does not limit the director's general authority to adopt rules pursuant to this subsection.

(6) The provisions of this section shall apply to all cessions after the effective date of this act under reinsurance agreements that have had an inception, anniversary, or renewal date not less than six (6) months after the effective date of this act.

History.

[I.C., § 41-514](#), as added by 1991, ch. 276, § 1, p. 712; am. 1994, ch. 93, § 1, p. 209; am. 1995, ch. 289, § 3, p. 967; am. and redesign. 2017, ch. 76, § 2,

p. 197.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 76, redesignated the section from § 41-514 and rewrote the section to the extent that a detailed comparison is impracticable.

Compiler's Notes.

This section was formerly codified as § 41-514 and was amended and redesignated as this section, pursuant to S.L. 2017, ch. 76, § 2.

As to national association of insurance commissioners (NAIC), referred to in this section, see *<http://naic.org>*.

As to the securities valuation office of NAIC, see *<http://naic.org/svo.htm>*.

The phrase “the effective date of this act,” used twice in subsection (6), refers to the effective date of S.L. 1991, Chapter 276, which was effective July 1, 1991.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-516. Individual or group accident and sickness insurance defined. — “Individual or group accident and sickness insurance” means any policy insuring against loss resulting from sickness or from bodily injury or death by accident, or both. “Individual or group accident and sickness insurance” shall also include comprehensive major medical coverage for medical and surgical benefits and high deductible health plans sold or maintained under the applicable provisions of [section 223 of the Internal Revenue Code](#).

History.

[I.C., § 41-516](#), as added by 2018, ch. 166, § 3, p. 339.

STATUTORY NOTES

Federal References.

[Section 223 of the Internal Revenue Code](#), referred to at the end of the section, is codified as [26 U.S.C.S. § 223](#).

Compiler’s Notes.

S.L. 2018, ch. 166, § 4 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

Chapter 6

ASSETS AND LIABILITIES

Sec.

41-601. “Assets” defined.

41-602. Assets as deductions from liabilities.

41-603. Assets not allowed.

41-604. Disallowance of “wash” transactions.

41-605. Liabilities, in general.

41-606. Unearned premium reserve.

41-607. Unearned premium reserve for marine and transportation insurance.

41-608. Reserve for disability insurance.

41-609. Loss reserves, liability insurance and worker’s compensation.

41-610. Increase of inadequate loss reserves.

41-611. Reserve for losses and unearned premiums — Title insurers.

41-611A. Mortgage guaranty insurance — Contingency reserve.

41-612. Standard valuation law — Life insurance.

41-613. Valuation of bonds.

41-614. Valuation of other securities.

41-615. Valuation of property.

41-616. Valuation of purchase money mortgages.

§ 41-601. “Assets” defined. — In any determination of the financial condition of an insurer, there shall be allowed as assets only such assets as are owned by the insurer and which consist of:

(1) Cash in the possession of the insurer, or in transit under its control, and including the true balance of any deposit in a solvent bank or trust company.

(2) Investments, securities, properties and loans acquired or held in accordance with this code, and in connection therewith the following items:

(a) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest.

(b) Declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset.

(c) Interest due or accrued upon a collateral loan in an amount not to exceed one (1) year's interest thereon.

(d) Interest due or accrued on deposits in solvent banks and trust companies, and interest due or accrued on other assets, if such interest is in the judgment of the director a collectible asset.

(e) Interest due or accrued on a mortgage loan, not in default of the contractual principal payments and the contractual interest payments, pursuant to the contractual terms of the loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes thereon over the unpaid principal; but in no event shall interest accrued for a period in excess of eighteen (18) months be allowed as an asset.

(f) Rent due or accrued on real property if such rent is not in arrears for more than three (3) months, and rent more than three (3) months in arrears if the payment of such rent be adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral.

(g) The unaccrued portion of taxes paid prior to the due date on real property.

(3) Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy.

(4) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer.

(5) Premiums in the course of collection, other than for life insurance, not more than three (3) months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the state of Idaho, any department, board, agency, or institution thereof, or any other political subdivision of the state of Idaho, including municipalities or specially chartered subdivisions, or by the United States government or by any of its instrumentalities.

(6) Installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which premiums apply.

(7) Notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on such basis, to the extent of the unearned premium reserves carried thereon.

(8) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under [section 41-511, Idaho Code](#).

(9) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty.

(10) Deposits or equities recoverable from underwriting associations, syndicates and reinsurance funds, or from any suspended banking institution, to the extent deemed by the director available for the payment of losses and claims and at values to be determined by him.

(11) Electronic and mechanical machines constituting a data processing and accounting system if the cost of such system is at least twenty-five thousand dollars (\$25,000), which cost shall be amortized in full over a period not to exceed ten (10) calendar years.

(12) All office equipment, office furniture, private passenger automobiles, deemed necessary for conduct of insurance business, the aggregate amount of which shall not at any one time exceed one percent (1%) of the other assets of the insurer.

(13) All assets, whether or not consistent with the provisions of this section, as may be allowed pursuant to the annual statement form approved by the director for the kinds of insurance to be reported upon therein.

(14) Other assets, not inconsistent with the provisions of this section, deemed by the director to be available for the payment of losses and claims, at values to be determined by him.

History.

1961, ch. 330, § 122, p. 645; am. 1969, ch. 214, § 14, p. 625; am. 1971, ch. 122, § 1, p. 408; am. 2003, ch. 219, § 1, p. 566.

STATUTORY NOTES

Cross References.

Annual statements, § 41-335.

Compiler's Notes.

In this section the name of the “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-602. Assets as deductions from liabilities. — Assets may be allowed as deductions from corresponding liabilities, and liabilities may be charged as deductions from assets, and deductions from assets may be charged as liabilities, in accordance with the form of annual statement applicable to the insurer as prescribed by the director, or otherwise in his discretion.

History.

1961, ch. 330, § 123, p. 645.

STATUTORY NOTES

Cross References.

Annual statements, § 41-335.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-603. Assets not allowed. — In addition to assets impliedly excluded by the provisions of [section 41-601, Idaho Code](#), the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

(1) Good will, trade names and other like intangible assets, except as expressly permitted and as prescribed by the national association of insurance commissioners' accounting practices and procedures.

(2) Advances to officers (other than policy loans) whether secured or not, and advances to employees, agents and other persons on personal security only.

(3) Stock of such insurer, owned by it, or any material equity therein or loans secured thereby, or any material proportionate interest in such stock acquired or held through the ownership by such insurer of an interest in another firm, corporation or business unit.

(4) Furniture, fixtures, furnishings, safes, vehicles (except as authorized in paragraph (12), [section 41-601, Idaho Code](#)), libraries, stationery, literature, and other equipment, machines, and supplies (other than data processing and accounting systems authorized under [section 41-601\(11\), Idaho Code](#)), except in the case of title insurers such materials and plants as the insurer is expressly authorized to invest in under [section 41-726, Idaho Code](#), and except, in the case of any insurer, such personal property as the insurer is permitted to hold pursuant to chapter 7, title 41, Idaho Code, or which is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch office and similar purposes.

(5) The amount, if any, by which the aggregate book value of investments is carried in the ledger assets of the insurer exceeds the aggregate value thereof as determined under this code.

History.

1961, ch. 330, § 124, p. 645; am. 1971, ch. 122, § 2, p. 408; am. 2006, ch. 207, § 1, p. 636.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 207, added the exception in subsection (1).

Compiler's Notes.

As to NAIC statutory accounting principles, see *<http://www.naic.org/ciprtopics/topicstatutoryaccountingprinciples.htm>*.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-604. Disallowance of “wash” transactions. — (1) The director shall disallow as an asset or as a credit against liabilities any reinsurance found by him after a hearing thereon to have been arranged for the purpose principally of deception as to the ceding insurer’s financial condition as of the date of any financial statement of the insurer. Without limiting the general purport of the foregoing provision, reinsurance of any substantial part of the insurer’s outstanding risks contracted for in fact within four (4) months prior to the date of any such financial statement and canceled in fact within four (4) months after the date of such statement, or reinsurance under which the reinsurer bears no substantial insurance risk or substantial risk of net loss to itself, shall prima facie be deemed to have been arranged for the purpose principally of deception within the intent of this provision.

(2) The director shall disallow as an asset any deposit, funds or other assets of the insurer found by him after a hearing thereon:

- (a) Not to be in good faith the property of the insurer, and
- (b) Not freely subject to withdrawal or liquidation by the insurer at any time for the payment or discharge of claims or other obligations arising under its policies, and
- (c) To be resulting from arrangements made principally for the purpose of deception as to the insurer’s financial condition as of the date of any financial statement of the insurer.

(3) No such disallowance of assets or credits shall be valid unless made by the director after a hearing of which notice was given the insurer within six (6) months after the date the financial statement of the insurer as to which such deception is claimed was filed with the director.

(4) The director may suspend or revoke the certificate of authority of any insurer which has knowingly been a party to any such deception or attempt thereat.

History.

1961, ch. 330, § 125, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-605. Liabilities, in general. — In any determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include:

- (1) The amount of its capital stock outstanding, if any.
- (2) The amount, estimated consistent with the provisions of this code, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement thereof.
- (3) With reference to life and disability insurance and annuity contracts:
 - (a) The amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted pursuant to this code which are applicable thereto.
 - (b) Reserves for disability benefits, for both active and disabled lives.
 - (c) Reserves for accidental death benefits.
 - (d) Any additional reserves which may be required by the director consistent with applicable customary and general practice in insurance accounting.
- (4) With reference to insurance other than specified in subsection (3) of this section, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter.
- (5) Taxes, expenses and other obligations due or accrued at the date of the statement.

History.

1961, ch. 330, § 126, p. 645.

STATUTORY NOTES

Cross References.

Annual statements, § 41-335.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-606. Unearned premium reserve. — (1) As to insurance against loss or damage to property (except as provided in section 41-607[, Idaho Code]), and as to all general casualty insurance and surety insurance, every insurer shall maintain an unearned premium reserve on all policies in force.

(2) The director may require that such reserves shall be equal to the unearned portions of the gross premiums in force after deducting applicable reinsurance in solvent insurers as computed on each respective risk from the policy's date of issue. If the director does not so require, the portions of the gross premium in force, less applicable reinsurance in solvent insurers, to be held as an unearned premium reserve, shall be computed according to the following table:

1 year or less		$\frac{1}{2}$
2 years	1st year	$\frac{3}{4}$
	2nd year	$\frac{1}{4}$
3 years	1st year	$\frac{5}{6}$
	2nd year	$\frac{1}{2}$
	3rd year	$\frac{1}{6}$
4 years	1st year	$\frac{7}{8}$
	2nd year	$\frac{5}{8}$
	3rd year	$\frac{3}{8}$
	4th year	$\frac{1}{8}$
5 years	1st year	$\frac{9}{10}$
	2nd year	$\frac{7}{10}$
	3rd year	$\frac{1}{2}$
	4th year	$\frac{3}{10}$
	5th year	$\frac{1}{10}$
Over 5 years	pro rata	

(3) In lieu of computation according to the foregoing table, the insurer at its option may compute all of such reserves on a monthly or more frequent pro rata basis.

(4) After adopting a method for computing such reserve, an insurer shall not change methods without approval of the insurance supervisory official of the insurer's domicile.

(5) This section does not apply to title insurance.

History.

1961, ch. 330, § 127, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in subsection (1) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-607. Unearned premium reserve for marine and transportation insurance. — As to marine and transportation insurance, the entire amount of premiums on trip risks not terminated shall be deemed unearned; and the director may require the insurer to carry a reserve equal to one hundred per cent (100%) of premiums on trip risks written during the month ended as of the date of statement.

History.

1961, ch. 330, § 128, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-608. Reserve for disability insurance. — For all disability insurance policies the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under such policies and be not less than the reserve according to appropriate standards set forth in regulations issued by the director and, in no event, less in the aggregate than the pro rata gross unearned premiums for such policies.

History.

1961, ch. 330, § 129, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-609. Loss reserves, liability insurance and worker's compensation. — Where called for by the form of annual statement required of the insurer, the reserve for outstanding losses under insurance against loss or damage from accident to or injuries suffered by an employee or other person and for which the insured is liable, shall be computed in accordance with the annual statement instructions and the accounting and procedures manual adopted by the national association of insurance commissioners, as provided in [section 41-335, Idaho Code](#).

History.

1961, ch. 330, § 130, p. 645; am. 1993, ch. 194, § 4, p. 492.

STATUTORY NOTES

Cross References.

Annual statements, § 41-335.

Compiler's Notes.

As to NAIC statutory accounting principles, see <http://www.naic.org/ciprtopics/topicstatutoryaccountingprinciples.htm>.

§ 41-610. Increase of inadequate loss reserves. — If loss experience shows that an insurer's loss reserves, however computed or estimated, are inadequate, the director shall require the insurer to maintain loss reserves in such additional amount as is needed to make them adequate. This section does not apply as to life insurance.

History.

1961, ch. 330, § 131, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-611. Reserve for losses and unearned premiums — Title insurers. — (1) Each title insurer shall maintain a special reserve in adequate amount to cover its liability as to losses incurred under policies issued by it.

(2) Each domestic title insurer shall establish and maintain a reserve for unearned premiums on its policies and guaranties in force. Such reserve shall at all times and for all purposes be considered a separate and distinct trust fund and shall be deemed and considered and shall constitute unearned portions of the original premiums and shall be charged as a reserve liability of the insurer in determining its financial condition. On all title insurance policies heretofore issued by the insurer, an unearned premiums reserve shall be set up and hereafter maintained in the amount which would have accumulated, as of the effective date of this code, if the foregoing requirement had been in existence ever since the date of the policy. Such reserve shall be computed as follows:

(a) With respect to owners and/or purchasers policies perpetual in term, monthly at the close of each month beginning as of July 1, 1947, the insurer shall set aside into the reserve ten per cent (10%) of the risk portion of the gross premium or fees received or to be received on account of policies written during the next preceding calendar month. After any such policy has been in force for ten (10) years, or upon earlier termination thereof for any cause, that portion of the reserve related thereto shall be released and may be used by the insurer thereafter for any lawful purpose.

(b) With respect to mortgage policies having a term, it shall be assumed for the purposes of this provision that all such policies have an average term of five (5) years from date of issue, and the unearned premium reserve thereon, commencing as of July 1, 1947, shall be computed upon the risk portion of the gross premium or fees charged for the policy according to the table for five (5) year term policies as provided in section 41-606(2)[, Idaho Code,] (unearned premium reserve). If such reserve is determined as at any date other than December 31 of any year,

the reserve shall be computed on a pro rata basis for the elapsed months of the calendar year in which the computation is made.

(c) If at any time, after examination of the insurer, the director determines that its reserve for unearned premiums computed as hereinabove provided is inadequate for the reasonable protection of its policy holders, the director may by order made after hearing thereon require such reserve to be computed upon such reasonable basis as may be prescribed in the order. No such order shall be retroactively effective.

(3) The unearned premium reserve of a foreign insurer shall be as prescribed or permitted by the laws of the insurer's domicile, unless found by the director to be inadequate for the reasonable protection of the insurer's Idaho policy holders. In event of such a finding, the insurer shall maintain unearned premium reserves upon business thereafter written in an amount not less than the reserves which would then be required of a domestic title insurer hereunder writing the same business.

History.

1961, ch. 330, § 132, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase "the effective date of this code" near the end of the introductory paragraph in subsection (2) refers to the effective date of S.L. 1961, Chapter 330, which was effective January 1, 1962.

The bracketed insertion near the end of the first sentence in paragraph (2) (b) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-611A. Mortgage guaranty insurance — Contingency reserve. —

In addition to reserves for unearned premiums and losses, as to mortgage guaranty insurance transacted by it an insurer shall establish and maintain a contingency reserve out of net premiums (gross premiums less premiums returned to policy holders) remaining after establishment of the unearned premium reserve. To the contingency reserve the insurer shall contribute an amount equal to fifty per cent (50%) of such remaining premiums. The annual contributions to the contingency reserve made during each calendar year shall be maintained for a period of one hundred twenty (120) months; except that in any year in which incurred losses of the insurer under mortgage guaranty insurance policies exceed thirty-five per cent (35%) of the corresponding earned premiums, the insurer may withdraw from the contingency reserve an amount equal to not more than the amount of such excess.

History.

I.C., § 41-611A, as added by 1972, ch. 79, § 2, p. 159.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-612. Standard valuation law — Life insurance. —

(1)(a) This section shall be known as the standard valuation law.

(b) For the purposes of this section the following definitions shall apply on or after the operative date of the valuation manual:

(i) “Accident and health insurance” means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness or medical conditions and as may be specified in the valuation manual. As used in this section and in the valuation manual, this term is synonymous with disability insurance as defined in [section 41-503, Idaho Code](#).

(ii) “Appointed actuary” means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (12)(b) of this section.

(iii) “Company” means an entity, which (a) has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and has at least one (1) such policy in force or on claim or (b) has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance or deposit-type contracts in this state.

(iv) “Deposit-type contract” means contracts that do not incorporate mortality or morbidity risks, and as may be specified in the valuation manual.

(v) “Life insurance” means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(vi) “NAIC” means the national association of insurance commissioners.

(vii) “Policyholder behavior” means any action a policyholder, contract holder or any other person with the right to elect options, such

as a certificate holder, may take under a policy or contract subject to this section including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract, but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(viii) “Principle-based valuation” means a reserve valuation that uses one (1) or more methods or one (1) or more assumptions determined by the insurer and is required to comply with subsection (15) of this section as specified in the valuation manual.

(ix) “Qualified actuary” means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American academy of actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(x) “Tail risk” means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(xi) “Valuation manual” means the manual of valuation instructions adopted by the NAIC as specified in this section or as subsequently amended.

(2) Annual valuation.

(a) Policies and contracts issued prior to the operative date of the valuation manual.

(i) The director shall annually value, or cause to be valued, the reserve liabilities (hereinafter “reserves”) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state, and issued on or after the operative date specified in [section 41-1927, Idaho Code](#), and prior to the operative date of the valuation manual. In the case of an alien insurer, such valuation shall be limited to its insurance transactions in the United States. In calculating such reserves, the director may use group methods and approximate averages for fractions of a year or otherwise.

He may accept in his discretion the insurer's calculation of such reserves. In lieu of the valuation of the reserves required of any foreign or alien insurer, he may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard provided in this section. Where any such valuation is made by the director, he may use the actuary of the department or employ an actuary for the purpose, and the reasonable compensation and expenses of the actuary, at a rate approved by the director, upon demand by the director supported by an itemized statement of such compensation and expenses, shall be paid by the insurer. When a domestic insurer furnishes the director with a valuation of its outstanding policies as computed by its own actuary or by an actuary deemed satisfactory for the purpose by the director, the valuation shall be verified by the actuary of the department without costs to the insurer.

(ii) The provisions set forth in subsections (4), (4a), (4b), (5), (6), (7), (8), (9), (10), (11) and (13) of this section shall apply to all policies and contracts, as appropriate, subject to this section, issued on or after the operative date specified in [section 41-1927, Idaho Code](#), and prior to the operative date of the valuation manual, and the provisions set forth in subsections (14) and (15) of this section shall not apply to any such policies and contracts.

(iii) The minimum standard for the valuation of policies and contracts issued prior to January 1, 1914, shall be that provided by the laws in effect immediately prior to that date.

(b) Policies and contracts issued on or after the operative date of the valuation manual.

(i) The director shall annually value, or cause to be valued, the reserve liabilities (hereinafter "reserves") for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the director may accept a valuation made, or caused to be made, by the insurance

supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section.

(ii) The provisions set forth in subsections (14) and (15) of this section shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(3) Except as provided in subsections (4) and (4a) of this section, the minimum standard for the valuation of such policies and contracts issued on and after January 1, 1914, and prior to the operative date of [section 41-1927, Idaho Code](#), (standard nonforfeiture law) shall be the American experience table of mortality and interest at three and one-half percent ($3\frac{1}{2}\%$) per annum. Not more than one (1) year shall be used as a preliminary term. Extra charges may be made in particular cases of invalid lives and other extra hazards, policies may be valued in groups, and approximate averages may be used for fractions of a year. Policies other than ordinary and twenty (20) payment life may be valued according to the modified preliminary term, with twenty (20) payment life policies as a basis for such valuation. This subsection applies only as to policies and contracts issued prior to the operative date of [section 41-1927, Idaho Code](#).

(4) Except as otherwise provided in subsections (4a) and (4b) of this section, the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of [section 41-1927, Idaho Code](#), (standard nonforfeiture law) shall be the commissioners reserve valuation methods defined in subsections (5), (6) and (10) of this section, three and one-half percent ($3\frac{1}{2}\%$) interest for all other such policies and contracts, except that the rate shall be four and one-half percent ($4\frac{1}{2}\%$) for individual annuity contracts, or in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, four percent (4%) interest for such policies issued prior to July 1, 1977, five and one-half percent ($5\frac{1}{2}\%$) interest for single premium life insurance policies and four and one-half percent ($4\frac{1}{2}\%$) interest for all other such policies issued on or after July 1, 1977, but prior to the operative date of subsection (9)(d) of the standard nonforfeiture law for life insurance as amended, seven percent (7%) interest for such policies issued on and after the operative date of subsection (9)(d) of the standard nonforfeiture law for life insurance as amended, and the following tables:

(a) For ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the commissioners 1941 standard ordinary mortality table for such policies issued prior to the operative date of subsection (9)(b) of [section 41-1927, Idaho Code](#); the commissioners 1958 standard ordinary mortality table for such policies issued on or after the operative date of subsection (9)(b) of the standard nonforfeiture law for life insurance as amended and prior to the operative date of subsection (9)(d) of the standard nonforfeiture law for life insurance as amended; except, that for any category of such policies issued on female risks, all modified net premiums and present values, referred to in subsections (5) and (10) of this section, may be calculated according to an age not more than six (6) years younger than the actual age of the insured; and for such policies issued on or after the operative date of subsection (9)(d) of the standard nonforfeiture law for life insurance as amended:

- (i) The commissioners 1980 standard ordinary mortality table, or
 - (ii) At the election of the company for any one (1) or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors, or
 - (iii) Any ordinary mortality table, adopted after 1980 by the NAIC, which is approved by rule promulgated by the director for use in determining the minimum standard of valuation for such policies.
- (b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 standard industrial mortality table for such policies issued prior to the operative date of subsection (9)(c) of [section 41-1927, Idaho Code](#), and for such policies issued on or after such operative date the commissioners 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the NAIC, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for such policies.
- (c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 standard annuity mortality table or, at the insurer's option, the annuity

mortality table for 1949, ultimate, or any modification of either of these tables approved by the director.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the group annuity mortality table for 1951, any modification of such table approved by the director, or, at the insurer's option, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates, adopted after 1980 by the NAIC, that are approved by regulation promulgated by the director for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after the operative date of [section 41-1927, Idaho Code](#), (standard nonforfeiture law) and prior to January 1, 1966, either such tables or, at the insurer's option, the class (3) disability table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the NAIC, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for such policies; for policies issued on or after the operative date of [section 41-1927, Idaho Code](#), (standard nonforfeiture law) and prior to January 1, 1966, either such table or, at the insurer's option, the intercompany double indemnity mortality table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the

director as being sufficient with relation to the benefits provided by such policies.

(4a) Except as provided in subsection (4b) of this section, the minimum standard of valuation for all individual annuity and pure endowment contracts issued on or after the operative date of this subsection, as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation methods defined in subsections (5) and (6) of this section and the following tables and interest rates:

(a) For individual annuity and pure endowment contracts issued prior to July 1, 1977, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any modification of this table approved by the director, and six percent (6%) interest for single premium immediate annuity contracts, and four and one-half percent (4 ½%) interest for all other individual annuity and pure endowment contracts.

(b) For individual single premium immediate annuity contracts issued on or after July 1, 1977, but prior to January 1, 1982, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any modification of this table approved by the director, and seven and one-half percent (7 ½%) interest.

(c) For individual single premium immediate annuity contracts issued on or after January 1, 1982, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the NAIC, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the director, and eleven percent (11%) interest.

(d) For individual annuity and pure endowment contracts issued on or after July 1, 1977, but prior to January 1, 1982, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table, or any modification of this table approved by the director,

and five and one-half percent (5 ½%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4 ½%) interest for all other such individual annuity and pure endowment contracts.

(e) For individual annuity and pure endowment contracts issued on or after January 1, 1982, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the NAIC, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the director, and eight percent (8%) interest.

(f) For annuities and pure endowments purchased prior to July 1, 1977, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table, or any modification of this table approved by the director, and six percent (6%) interest.

(g) For annuities and pure endowments purchased on or after July 1, 1977, but prior to January 1, 1982, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table, or any modification of this table approved by the director, and seven and one-half percent (7 ½%) interest.

(h) For annuities and pure endowments purchased on or after January 1, 1982, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table or any group annuity mortality table, adopted after 1980 by the NAIC, that is approved by regulation promulgated by the director for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the director, and eleven percent (11%) interest.

After July 1, 1973, any insurer may file with the director a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1979, which shall be the operative date of this

subsection for such insurer, provided that an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1979.

(4b) For any calendar year on or after the effective date of subsection (9)(d) of the standard nonforfeiture law for life insurance in the case of life insurance policies issued on or after such effective date, and for any calendar year on or after January 1, 1982, in the case of:

(a) Individual annuity and pure endowment contracts issued on or after January 1, 1982;

(b) Annuities and pure endowments purchased on or after January 1, 1982, under group annuity and pure endowment contracts; and

(c) The net increase, if any, in any particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts, the company may elect, for the purpose of determining the minimum standard for valuation, for any category of policy or contract, the calendar year statutory valuation interest rate as defined in this subsection in lieu of the interest rate specified in subsection (4) or (4a) of this section.

The provisions of this subsection shall be applicable to:

A. The interest rates used in determining the minimum standard for the valuation of:

a. Life insurance policies issued in a particular calendar year, on or after the operative date of subsection (9)(d) of the standard nonforfeiture law for life insurance;

b. Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

c. Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and

d. The net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts

shall be the calendar year statutory valuation interest rates as defined in this subsection.

B. Calendar year statutory valuation interest rates:

- a. The calendar year statutory valuation interest rates, I , shall be determined as follows and the results rounded to the nearer one-quarter of one percent ($\frac{1}{4}$ of 1%).

1. For life insurance,

$$I = .03 + W (R^1 - .03) + \underline{W} (R^2 - .09);$$

2

2. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$$I = .03 + W (R - .03)$$

where R^1 is the lesser of R and $.09$;

R^2 is the greater of R and $.09$;

R is the reference interest rate defined in this subsection and W is the weighting factor defined in this subsection,

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in 2. above, the formula for life insurance stated in 1. above shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten (10) years and the formula for single premium immediate annuities stated in 2. above shall apply to annuities and guaranteed interest contracts with guarantee duration of ten (10) years or less,
4. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in 2. above shall apply,

5. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in 2. above shall apply.

b. However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent ($\frac{1}{2}$ of 1%), the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when subsection (9)(d) of the standard nonforfeiture law for life insurance becomes operative.

C. Weighting factors

a. The weighting factors referred to in the formulas stated above are given in the following tables:

1. Weighting factors for life insurance:

Guarantee

Duration Weighting

(Years) Factors

10 or less .50

More than 10, but not more than 20 .45

More than 20 .35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance

with premium rates or nonforfeiture values, or both, which are guaranteed in the original policy;

2. Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

3. Weighting factors for other annuities and for guaranteed interest contracts, except as stated in 2. above, shall be as specified in tables (i), (ii) and (iii) below, according to the rules and definitions in (iv), (v) and (vi) below:

(i) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Weighting Factor

Duration for Plan Type

(Years) A B C

5 or less .80 .60 .50

More than 5, but not more

than 10 .75 .60 .50

More than 10, but not more

than 20 .65 .50 .45

More than 20 .45 .35 .35

Plan Type

(ii) A B C

For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (i) above

increased by: .15 .25 .05

(iii)

For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one (1) year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve (12) months beyond the valuation date, the factors shown in (i) or derived in (ii) increased by: .05 .05 .05

(iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty (20) years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the

number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(v) Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only:

- (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or
- (2) without such adjustment but in installments over five (5) years or more; or
- (3) as an immediate life annuity; or
- (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only:

- (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or
- (2) without such adjustment but in installments over five (5) years or more; or
- (3) no withdrawal permitted.

At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five (5) years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five (5) years, either:

- (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; or
- (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(vi) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and

other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

D. Reference interest rate

a. The reference interest rate referred to in paragraph B. of this subsection shall be defined as follows:

1. For life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's corporate bond yield average — monthly average corporates, as published by Moody's Investors Service, Inc.

b. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or year of purchase, of Moody's corporate bond yield average — monthly average corporates, as published by Moody's Investors Service, Inc.

c. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year of issue basis, except as stated in b. above, with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of

Moody's corporate bond yield average — monthly average corporates, as published by Moody's Investors Service, Inc.

d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in b. above, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending June 30 of the calendar year of issue or purchase, of Moody's corporate bond yield average — monthly average corporates, as published by Moody's Investors Service, Inc.

e. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of Moody's corporate bond yield average — monthly average corporates, as published by Moody's Investors Service, Inc.

f. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in b. above, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of Moody's corporate bond yield average — monthly average corporates, as published by Moody's Investors Service, Inc.

E. Alternative method for determining reference interest rates

a. In the event that Moody's corporate bond yield average — monthly average corporates is no longer published by Moody's Investors Service, Inc., or in the event that the NAIC determines that Moody's corporate bond yield average — monthly average corporates, as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the NAIC and approved by regulation promulgated by the director, may be substituted.

(5) Commissioners reserve valuation method.

(a) Except as otherwise provided in subsections (6) and (10) of this section reserves according to the commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (i) over (ii) as follows:

(i) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one (1) per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen (19) year premium whole life plan for insurance of the same amount at an age one (1) year higher than the age at issue of such policy.

(ii) A net one (1) year term premium for such benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after January 1, 1986, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (10) of this section, be the greater of the reserve as of such policy anniversary calculated as

described in the preceding paragraph and the reserve as of such policy anniversary calculated as described in that paragraph, but with (a) the value defined in subparagraph (i) of that paragraph being reduced by fifteen percent (15%) of the amount of such excess first year premium, (b) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (c) the policy being assumed to mature on such date as an endowment, and (d) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest basis stated in subsections (4) and (4b) of this section shall be used.

(b) Reserves according to the commissioners reserve valuation method for:

(i) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums,

(ii) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under [section 408 of the Internal Revenue Code](#), as now or hereafter amended,

(iii) Disability and accidental death benefits in all policies and contracts, and

(iv) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts,

shall be calculated by a method consistent with the principles of subsection (5)(a) of this section, except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

(6) Individual annuity and pure endowment reserves.

(a) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts

purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under [section 408 of the Internal Revenue Code](#), as now or hereafter amended.

(b) Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(7) Minimum aggregate reserves. In no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the operative date of [section 41-1927, Idaho Code](#), be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (5), (6), (10) and (11) of this section and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(8) Optional reserve basis.

(a) Reserves for policies and contracts issued prior to the operative date of [section 41-1927, Idaho Code](#), may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.

(b) For any category of policies, contracts or benefits specified in subsections (4), (4a) and (4b) of this section, issued on or after the operative date of [section 41-1927, Idaho Code](#), (the standard nonforfeiture law), reserves may be calculated, at the option of the insurer, according to any standard or standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in the policies or contracts.

(9) Lower valuations. An insurer which at any time had adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under this section may, with the approval of the director, adopt any lower standard of valuation, but not lower than the minimum provided under this section.

(10) Minimum reserve. If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon, but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsections (4) and (4b) of this section.

Provided that for any life insurance policy issued on or after January 1, 1986, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall

be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (5) of this section, ignoring the second paragraph of subsection (5) of this section. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (5) of this section, including the second paragraph of that subsection, and the minimum reserve calculated in accordance with this subsection.

(11) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on the then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (5), (6) and (10) of this section, the reserves which are held under any such plan must:

- (a) Be appropriate in relation to the benefits and the pattern of premiums for that plan, and
 - (b) Be computed by a method which is consistent with the principles of this standard valuation law,
- as determined by rules promulgated by the director.

(12) Actuarial opinion of reserves.

(a) Actuarial opinion prior to the operative date of the valuation manual.

(i) Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The director by rule shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(ii) Actuarial analysis of reserves and assets supporting such reserves.

1. Every life insurance company, except as exempted by or pursuant to rule, shall also annually include in the opinion required by subparagraph (i) of this subparagraph, an opinion of the same

qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts including, but not limited to, the benefits under and expenses associated with the policies and contracts.

2. The director may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required in this subsection.

(iii) Requirements for opinion in subparagraph (ii) of this paragraph. Each opinion required in subparagraph (ii) of this paragraph shall be governed by the following provisions:

1. A memorandum, in form and substance acceptable to the director as specified by rule, shall be prepared to support each actuarial opinion.

2. If the insurance company fails to provide a supporting memorandum at the request of the director within a period specified by rule or the director determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rules or otherwise unacceptable to the director, the director may engage a qualified actuary at the expense of the company to review the opinion and prepare such supporting memorandum as is required by the director.

(iv) Requirements for all opinions subject to paragraph (a) of this subsection. Every opinion subject to paragraph (a) of this subsection shall be governed by the following provisions:

1. The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1995.

2. The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the director as specified by rule.
3. The opinion shall be based on standards adopted from time to time by the actuarial standards board and on such additional standards as the director may by rule prescribe.
4. In the case of an opinion required to be submitted by a foreign or alien company, the director may accept the opinion filed by that company with the insurance supervisory official of another state if the director determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.
5. For the purposes of this subsection, “qualified actuary” means a member in good standing of the American academy of actuaries who meets the requirements set forth in such regulations.
6. Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person (other than the insurance company and the director) for any act, error, omission, decision or conduct with respect to the actuary’s opinion.
7. Disciplinary action by the director against the company or the qualified actuary shall be defined by rule by the director.
8. Any memorandum in support of the opinion, and any other material provided by the company to the director in connection therewith, shall be kept confidential by the director and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required in this subsection or by rule promulgated hereunder; provided however, that the memorandum or other material may otherwise be released by the director (A) with the written consent of the company or (B) to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the director for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited

by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall no longer be confidential.

(b) Actuarial opinion of reserves after the operative date of the valuation manual.

(i) Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the director shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion, including any items deemed to be necessary to its scope.

(ii) Actuarial analysis of reserves and assets supporting reserves. Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the director, except as exempted in the valuation manual, shall also annually include in the opinion required by subparagraph (i) of this paragraph, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(iii) Requirements for opinions subject to paragraph (b)(ii) of this subsection. Each opinion required by paragraph (b)(ii) of this subsection shall be governed by the following provisions:

1. A memorandum, in form and substance as specified in the valuation manual, and acceptable to the director, shall be prepared to support each actuarial opinion.

2. If the insurance company fails to provide a supporting memorandum at the request of the director within a period specified in the valuation manual or the director determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the director, the director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the director.

(iv) Requirements for opinions subject to this paragraph. Every opinion shall be governed by the following provisions:

1. The opinion shall be in form and substance as specified in the valuation manual and acceptable to the director.

2. The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

3. The opinion shall apply to all policies and contracts subject to subparagraph (ii) of this paragraph, plus other actuarial liabilities as may be specified in the valuation manual.

4. The opinion shall be based on standards adopted from time to time by the actuarial standards board or its successor, and on such additional standards as may be prescribed in the valuation manual.

5. In the case of an opinion required to be submitted by a foreign or alien company, the director may accept the opinion filed by that company with the insurance supervisory official of another state if the director determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

6. Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the director, for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

7. Disciplinary action by the director against the company or the qualified actuary shall be defined by rule by the director.

(13) Minimum standard for accident and health insurance contracts. For disability insurance contracts issued on or after the operative date specified in [section 41-1927, Idaho Code](#), and prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the director by regulation. For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (2)(b) of this section.

(14) Valuation manual for policies issued on or after the operative date of the valuation manual.

(a) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (2)(b) of this section, except as provided under paragraph (e) or (g) of this subsection.

(b) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(i) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths ($\frac{3}{4}$) of the members voting, whichever is greater.

(ii) The standard valuation law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(iii) The standard valuation law, as amended by the NAIC in 2009, or legislation, including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions: the fifty (50) states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam and Puerto Rico.

The director may confirm the operative date of the valuation manual by bulletin or otherwise.

(c) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when both of the following have occurred:

(i) The change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

1. At least three-fourths ($\frac{3}{4}$) of the members of the NAIC voting, but not less than a majority of the total membership; and
2. Members of the NAIC representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements most recently available prior to the vote specified in this paragraph: life, accident and health annual statements; health annual statements; or fraternal annual statements;

(ii) The change to the valuation manual has been adopted by the director by rule, administrative order or bulletin.

(d) The valuation manual must specify all of the following:

(i) Minimum valuation standards for and definitions of the policies or contracts subject to subsection (2)(b) of this section. Such minimum valuation standards shall be:

1. The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection (2)(b) of this section;
2. The commissioner's annuity reserve valuation method for annuity contracts subject to subsection (2)(b) of this section; and
3. Minimum reserves for all other policies or contracts subject to subsection (2)(b) of this section.

(ii) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in subsection (15)(a) of this section and the minimum valuation standards consistent with those requirements;

(iii) For policies and contracts subject to a principle-based valuation under subsection (15) of this section:

1. Requirements for the format of reports to the director under subsection (15)(b)(iii) of this section and which shall include information necessary to determine if the valuation is appropriate and in compliance with this section;
2. Assumptions shall be prescribed for risks over which the company does not have significant control or influence.
3. Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(iv) For policies not subject to a principle-based valuation under subsection (15) of this section the minimum valuation standard shall either:

1. Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or
2. Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(v) Other requirements including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(vi) The data and form of the data required under subsection (16) of this section, with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(e) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the director, in compliance with this section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the director by rule.

(f) The director may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The director may rely upon the opinion, regarding provisions contained within this section, of a qualified actuary engaged by the commissioner of another state, district or territory of the United States. As used in this paragraph, the term "engage" includes employment and contracting.

(g) The director may require a company to change any assumption or method that in the opinion of the director is necessary in order to comply with the requirements of the valuation manual or this section, and the company shall adjust the reserves as required by the director. The director may take other disciplinary action as permitted pursuant to chapter 2, title 41, Idaho Code.

(15) Requirements of a principle-based valuation.

(a) A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(i) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. Policies or contracts with significant tail risk shall reflect conditions appropriately adverse to quantify the tail risk;

(ii) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(iii) Incorporate assumptions that are derived in one (1) of the following manners:

1. The assumption is prescribed in the valuation manual.

2. For assumptions that are not prescribed, the assumptions shall:

(A) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(B) To the extent that company data is not available, relevant or statistically credible, be established utilizing other relevant, statistically credible experience;

(iv) Provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(b) A company using a principle-based valuation for one (1) or more policies or contracts subject to this subsection as specified in the valuation manual shall:

(i) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(ii) Provide to the director and the company's board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year;

(iii) Develop, and file with the director upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(c) A principle-based valuation may include a prescribed formulaic reserve component.

(16) Experience reporting for policies in force on or after the operative date of the valuation manual. A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(17) Confidentiality.

(a) For purposes of this subsection, “confidential information” means:

(i) A memorandum in support of an opinion submitted under subsection (12) of this section and any other documents, materials and other information including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the director or any other person in connection with such memorandum;

(ii) All documents, materials and other information including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the director or any other person in the course of an examination made under subsection (14)(f) of this section; provided however, that if an examination report or other material prepared in connection with an examination made under chapter 2, title 41, Idaho Code, is not held as private and confidential information under chapter 2, title 41, Idaho Code, an examination report or other material prepared in connection with an examination made under subsection (14)(f) of this section shall not be confidential information to the same extent as if such examination report or other material had been prepared under chapter 2, title 41, Idaho Code.

(iii) Any reports, documents, materials and other information developed by a company in support of, or in connection with, an annual certification by the company under subsection (15)(b)(ii) of this section evaluating the effectiveness of the company’s internal controls with respect to a principle-based valuation and any other documents, materials and other information including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the director or any other person in connection with such reports, documents, materials and other information;

(iv) Any principle-based valuation report developed under subsection (15)(b)(iii) of this section and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the director or any other person in connection with such report; and

(v) Any documents, materials, data and other information submitted by a company under subsection (16) of this section (collectively, “experience data”) and any other documents, materials, data and other

information including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that includes any potentially company-identifying or personally identifiable information, that is provided to or obtained by the director (together with any “experience data,” the “experience materials”) and any other documents, materials, data and other information including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the director or any other person in connection with such experience materials.

(b) Privilege for, and confidentiality of, confidential information.

(i) Except as provided in this subsection, a company’s confidential information is confidential by law and privileged, and shall not be subject to public disclosure under chapter 1, title 74, Idaho Code, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action; provided however, that the director is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the director’s official duties;

(ii) Neither the director nor any person who received confidential information while acting under the authority of the director shall be permitted or required to testify in any private civil action concerning any confidential information;

(iii) In order to assist in the performance of the director’s duties, the director may share confidential information:

1. With other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries; and
2. In the case of confidential information specified in paragraph (a) (i) and (iv) of this subsection only, with the actuarial board for counseling and discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal and international law enforcement officials.

In the case of paragraph (b)(iii)1. and 2. of this subsection, provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data and other information in the same manner and to the same extent as required for the director.

(iv) The director may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the actuarial board for counseling and discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information.

(v) The director may enter into agreements governing sharing and use of information consistent with this paragraph.

(vi) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the director under this subsection or as a result of sharing as authorized in subparagraph (iii) of this paragraph.

(vii) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this paragraph shall be available and enforced in any proceeding in, and in any court of, this state.

(viii) In this subsection, “regulatory agency,” “law enforcement agency” and the “NAIC” include, but are not limited to, their employees, agents, consultants and contractors.

(c) Notwithstanding paragraph (b) of this subsection, any confidential information specified in paragraph (a)(i) and (iv) of this subsection:

(i) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsection (12) of this section or principle-based valuation report developed under

subsection (15)(b)(iii) of this section by reason of an action required by this section or by rule promulgated hereunder;

(ii) May otherwise be released by the director with the written consent of the company; and

(iii) Once any portion of a memorandum in support of an opinion submitted under subsection (12) of this section or a principle-based valuation report developed under subsection (15)(b)(iii) of this section is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

(18) Single state examination:

(a) The director may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Idaho from the requirements of subsection (14) of this section provided:

(i) The director has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(ii) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual, in addition to any requirements established by the director and promulgated by rule.

(b) For any company granted an exemption under this section, subsections (4), (4a), (4b), (5), (6), (7), (8), (9), (10), (11), (12) and (13) of this section shall be applicable. With respect to any company applying this exemption, any reference to subsection (14) found in subsections (4), (4a), (4b), (5), (6), (7), (8), (9), (10), (11), (12) and (13) of this section shall not be applicable.

History.

1961, ch. 330, § 133, p. 645; am. 1965, ch. 307, § 1, p. 822; am. 1969, ch. 214, § 15, p. 625; am. 1973, ch. 274, § 1, p. 574; am. 1977, ch. 265, § 1, p. 773; am. 1982, ch. 205, § 1, p. 543; am. 1996, ch. 97, § 1, p. 293; am. 1999, ch. 74, § 1, p. 197; am. 2016, ch. 68, § 1, p. 205.

STATUTORY NOTES

Cross References.

Standard nonforfeiture law — Life insurance, § 41-1927.

Amendments.

The 2016 amendment, by ch. 68, rewrote the section to the extent that a detailed comparison would be impracticable, updating the valuation method used for life insurance premiums to Principle Based Reserves.

Federal References.

Section 408 of the Internal Revenue Code, referred to in subsections (5)(b)(ii) and (6)(a) of this section, is compiled as **26 U.S.C.S. § 408**.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The standard nonforfeiture law for life insurance, referenced throughout this section, is codified as § 41-1927. For the operative date of § 41-1927, see subsection (14) of that section.

For further information on the American academy of actuaries qualification standards, see <http://www.actuary.org/content/us-qualification-standards>.

For further information on the national association of insurance commissioners (NAIC), referred to throughout this section, see <http://www.naic.org>.

For further information on Moody's investors services, see <https://www.moody.com/>.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-613. Valuation of bonds. — (1) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

(a) If purchased at par, at the par value.

(b) If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or in lieu of such method, according to such generally accepted method of valuation elected by the insurer and approved by the director.

(c) Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage or express charges paid in the acquisition of such securities.

(d) Unless otherwise provided by valuation established or approved by the director, no such security shall be carried at above the call price for the entire issue during any period within which the security may be so called.

(2) The director shall have full discretion in determining the method of calculating values according to the rules set forth in this section, but no such method or valuation shall be inconsistent with any applicable valuation method used by insurers in general, or any such method then currently formulated or approved by the national association of insurance commissioners or its successor organization.

History.

1961, ch. 330, § 134, p. 645; am. 1993, ch. 194, § 5, p. 492.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

For further information on the national association of insurance commissioners (NAIC), referred to throughout this section, see <http://www.naic.org>.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-614. Valuation of other securities. — (1) Securities, other than those referred to in [section 41-613, Idaho Code](#), held by an insurer may be valued, in the discretion of the director:

(a) At their market value if market value can be reasonably ascertained, or

(b) If the issuer is an insurer, at their unadjusted book value as determined by the issuer's convention form financial statement filed with insurance public supervisory officials, or

(c) Any other value which the insurer can substantiate to the satisfaction of the director. In addition to other applicable bases of valuation, the director shall give due consideration to valuation based upon:

(i) The net worth of the issuer as shown by financial statements acceptable to the director.

(ii) The acquisition cost of the security to the insurer, adjusted in accordance with generally accepted accounting principles to reflect changes since such acquisition in the issuer's financial condition and business.

(2) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, according to a generally accepted method of computation approved by the director.

(3) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of the net value thereof as based upon those assets only of the subsidiary which would be eligible under chapter 7, title 41, Idaho Code, for investment of the funds of the insurer directly.

(4) No valuations under this section shall be inconsistent with any applicable valuation or method then currently formulated or approved by the national association of insurance commissioners or its successor organization.

History.

1961, ch. 330, § 135, p. 645; am. 1971, ch. 122, § 3, p. 408; am. 1972, ch. 369, § 7, p. 1072; am. 1993, ch. 194, § 6, p. 492.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

As to national association of insurance commissioners, referred to in subsection (4), see *<http://naic.org>*.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

Section 37 of S.L. 1993, ch. 194 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

§ 41-615. Valuation of property. — (1) Real property acquired pursuant to a mortgage loan or contract for sale, in the absence of a recent appraisal deemed by the director to be reliable, shall not be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of such acquisition, together with any taxes and expenses paid or incurred in connection with such acquisition, and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.

(2) Other real property held by an insurer shall not be valued at an amount in excess of fair value as determined by recent appraisal. If valuation is based on an appraisal more than three years old, the director may at his discretion call for and require a new appraisal in order to determine fair value.

History.

1961, ch. 330, § 136, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-616. Valuation of purchase money mortgages. — Purchase money mortgages on real property referred to in subsection (1) of section 41-615[, Idaho Code] of this chapter shall be valued in an amount not exceeding the acquisition cost of the real property covered thereby or ninety per cent (90%) of the fair value of such real property, whichever is less.

History.

1961, ch. 330, § 137, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the middle of the section was added by the compiler to conform to the statutory citation style.

Chapter 7

INVESTMENTS

Sec.

41-701. Investments.

41-702. Eligible investments.

41-703. General qualifications.

41-704. Authorization of investments.

41-705. Record of investments.

41-706. Diversification of investments.

41-707. Public obligations.

41-708. Obligations and stock of certain federal agencies.

41-709. Irrigation district bonds.

41-710. International bank.

41-711. Corporate obligations.

41-712. Certain terms defined.

41-713. Preferred stocks — Diversification.

41-714. Common stocks.

41-715. Insurance stocks.

41-716. Investment trust securities.

41-717. Equipment trust obligations.

41-718. Policy loans.

41-719. Collateral loans.

41-720. Savings and share accounts.

41-721. Mortgage loans and contracts.

41-722. Mortgage loan limited by property value.

- 41-723. Appraisal — Limit of amount loaned.
- 41-724. “Improved real property” defined.
- 41-725. “Encumbrance” defined.
- 41-726. Special investments by title insurer.
- 41-727. Foreign securities.
- 41-728. Real estate.
- 41-729. Time limit for disposal of real estate.
- 41-730. Disposal of ineligible property and securities.
- 41-731. Prohibited investments and investment underwriting.
- 41-732. Domestic reciprocal insurer.
- 41-733. Subsidiary investments.
- 41-734. Separate account funds.
- 41-735. Miscellaneous investments.
- 41-736. Permitted investments.

§ 41-701. Investments. — (1) Funds of a domestic insurer shall be invested, reinvested and used in the manner and subject to the conditions, restrictions and limitations set forth in this chapter.

(2) Investments of a foreign or alien insurer which would be authorized for a like domestic insurer shall be allowed as assets in any determination of its financial condition. Other investments of a foreign or alien insurer which are authorized by the laws of its domicile may be so allowed at the discretion of the director.

(3) The director may adopt rules establishing standards and limitations for investments by insurers that are not otherwise specifically permitted or prohibited in this chapter. In the absence of a rule prohibiting such, all assets shall be valued according to rules promulgated by the national association of insurance commissioners (NAIC), NAIC's valuation of securities office or by NAIC's financial condition subcommittee.

History.

1961, ch. 330, § 138, p. 645; am. 1994, ch. 240, § 5, p. 751.

STATUTORY NOTES

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (3), see <http://naic.org>.

Section 13 of S.L. 1994, ch. 240 read: "Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993." Section 36 of S.L. 1993, ch. 194 provided, "For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in

effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-702. Eligible investments. — (1) Insurers shall invest in or lend their funds on the security of, and shall hold as invested assets, only cash and eligible investments as prescribed in this chapter.

(2) Any particular investment held by an insurer on the effective date of this code, and which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately prior to such effective date, shall be deemed to be an eligible investment.

(3) Eligibility of an investment shall be determined as of the date of its making or acquisition, except as stated in subsection (2) above.

(4) Any investment limitation based upon the amount of the insurer's assets or particular funds shall relate to such assets or funds as shown by the insurer's annual statement as of the December 31 next preceding date of making or acquisition of the investment by the insurer, or as shown by a current financial statement.

History.

1961, ch. 330, § 139, p. 645.

STATUTORY NOTES

Cross References.

Annual statement, § 41-335.

Compiler's Notes.

The phrase "the effective date of this code" in subsection (2) refers to the effective date of S.L. 1961, ch. 330, which was January 1, 1962.

§ 41-703. General qualifications. — (1) No security or investment (other than real and personal property acquired under [section 41-728, Idaho Code](#), real property owned) shall be eligible for acquisition unless it is interest bearing or interest accruing or by its character entitled to receive dividends or income when declared or paid, including discounted and zero interest certificates of accrual on public and corporate obligations, is not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing thereon.

(2) No security or investment shall be eligible for purchase at a price above its market value.

(3) No provision of this chapter shall prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets, or under a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investment so acquired which is not otherwise eligible under this chapter shall be disposed of pursuant to [section 41-730, Idaho Code](#), if personal property or securities, or pursuant to [section 41-729, Idaho Code](#), if real property.

History.

1961, ch. 330, § 140, p. 645; am. 1969, ch. 214, § 16, p. 625; am. 1985, ch. 231, § 1, p. 551.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-704. Authorization of investments. — An insurer shall not make, sell, or exchange any investment or loan, except as to the policy loans or annuity contract loans of a life insurer, unless the same is authorized or approved by its board of directors or by a committee charged by the board of directors or the by-laws with the duty of making such investment, loan, sale or exchange. The minutes of any such committee shall be recorded and reports thereof shall be submitted to the board of directors for approval or disapproval.

History.

1961, ch. 330, § 141, p. 645.

§ 41-705. Record of investments. — (1) The insurer shall make a written record in permanent form showing the authorization as to each investment or loan of its funds, which record shall be signed by an officer of the insurer or by the chairman of the committee authorizing or approving the investment or loan.

(2) As to each such investment or loan, the insurer's record shall contain:

(a) In the case of loans: The name of the borrower; the location of the property; a physical description and the appraised value of the security; the amount of the loan, rate of interest and terms of repayment.

(b) In the case of securities: The name of the obligor; a description of the security; the amount invested, the rate of interest or dividend, the maturity and yield based upon the purchase price.

(c) In the case of real estate: The location and legal description of the property; a physical description and the appraised value; the purchase price and terms.

(d) In the case of all investments:

(i) The amount of expenses and commissions directly incurred on account of any investment or loan and by whom and to whom payable if not covered by contracts with mortgage loan representatives or correspondents which are part of the insurer's records.

(ii) The name of any officer or director of the insurer with an interest in the investment and the nature of the interest. For purposes of this subparagraph, an officer or a director of an insurer has an interest in an investment if:

1. The insurer acquires or sells the investment directly or indirectly from or to the officer or director; or

2. The officer or director holds a direct, an indirect, or a contingent interest in the securities or loan representing the investment or in the assets of the person in whose behalf the investment or loan is made.

This paragraph shall not apply to an investment by an officer or a director in common stock, preferred stock, or bonds of a United States publicly traded corporation if the director or officer's interest in such publicly traded corporation constitutes less than one percent (1%) of the corporation's total outstanding stock or bonds, in exchange-traded common stock funds or bond funds if listed on a United States regulated exchange, or in mutual funds registered with the securities and exchange commission.

History.

1961, ch. 330, § 142, p. 645; am. 1983, ch. 189, § 1, p. 510; am. 2019, ch. 112, § 1, p. 369.

STATUTORY NOTES

Amendments.

The 2019 amendment, by ch. 112, in subsection (2), substituted “directly incurred” for “if any incurred” in paragraph (d)(i), and rewrote paragraph (d)(ii), which formerly read: “The name of any officer or director of the insurer having any direct, indirect, or contingent interest in the securities or loan representing the investment, or in the assets of the person in whose behalf the investment or loan is made, and the nature of such interest.”

§ 41-706. Diversification of investments. — An insurer shall invest in or hold as assets categories of investments within applicable limits as follows only:

(1) One (1) person. An insurer shall not, except with the consent of the director, have at any one (1) time any combination of investments in or loans upon the security of the obligations, property, or securities of any one (1) person, institution, corporation, or municipal corporation, aggregating an amount exceeding ten percent (10%) of the insurer's assets. This restriction shall not apply as to investments or deposits fully insured by the federal deposit insurance corporation or to general obligations of the United States of America or of any state or include policy or annuity contract loans made under [section 41-718, Idaho Code](#), or to assets subject to section 41-715 or 41-3803, Idaho Code, or to any one (1) domestic reciprocal insurer which exclusively insures members who are political subdivisions, as defined by section 6-902 2., Idaho Code, provided that all such investments comply with the public depository laws.

(2) Voting stock. An insurer shall not invest in or hold at any one (1) time more than ten percent (10%) of the outstanding voting stock of any corporation, except with the consent of the director given with respect to voting rights of preference stock during default of dividends. This provision does not apply as to stock of subsidiaries of the insurer or a companion company or companies under substantially the same management at the time of purchase, as referred to in section 41-715 or 41-3803, Idaho Code.

(3) Minimum capital. An insurer (other than title insurer) shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under this code of a domestic stock insurer transacting like kinds of insurance, only in cash and the securities provided for under the following sections of this chapter: [section 41-707, Idaho Code](#), (public obligations), and [section 41-721, Idaho Code](#), (real estate mortgages and contracts).

(4) Life insurance reserves. A life insurer shall also invest and keep invested its funds in an amount not less than the reserves under its life insurance policies and annuity contracts in force, as prescribed by [section](#)

41-612, Idaho Code, in cash and/or the securities or investments allowed under this chapter, other than in common stocks, insurance stocks and stocks of subsidiaries of the insurer.

(5) Other specific limits. Limits as to investments in the category of real estate shall be as provided in section 41-728, Idaho Code; and other specific limits shall apply as stated in the sections dealing with other respective kinds of investments.

History.

1961, ch. 330, § 143, p. 645; am. 1971, ch. 122, § 4, p. 408; am. 1974, ch. 91, § 1, p. 1187; am. 1978, ch. 89, § 1, p. 165; am. 1983, ch. 189, § 2, p. 510; am. 1993, ch. 194, § 7, p. 492; am. 1996, ch. 245, § 1, p. 775; am. 2013, ch. 266, § 3, p. 652.

STATUTORY NOTES

Cross References.

Public depository law, § 57-101 et seq.

Amendments.

The 2013 amendment, by ch. 266, updated references in subsections (1) and (2) in light of the 2013 revision at chapter 38, title 41, Idaho Code.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

For more on the federal deposit insurance corporation, referred to in subsection (1), see <http://www.fdic.gov>.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be

held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-707. Public obligations. — An insurer may invest any of its funds in bonds or other evidences of debt, not in default as to principal or interest, which are valid and legally authorized obligations issued, assumed or guaranteed by the United States or by any state thereof or by any territory or possession of the United States or by the District of Columbia, or of the government of Canada or any provinces thereof, or by any county, city, town, village, municipality or district therein or by any political subdivision thereof or by any civil division or public instrumentality of one or more of the foregoing, if, by statutory or other legal requirements applicable thereto, such obligations are payable, as to both principal and interest, (1) from taxes levied or required to be levied upon all taxable property or all taxable income within the jurisdiction of such governmental unit or, (2) from adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment, but not including any obligation payable solely out of special assessments on properties benefited by local improvements unless adequate security is evidenced by the ratio of assessment to the value of the property or the obligation is additionally secured by an adequate guaranty fund required by law.

History.

1961, ch. 330, § 144, p. 645; am. 1969, ch. 214, § 17, p. 625.

§ 41-708. Obligations and stock of certain federal agencies. — An insurer may invest in the obligations, and/or stock where stated, of the following agencies of the government of the United States of America, whether or not such obligations are guaranteed by such government:

- (1) Commodity credit corporation.
- (2) Federal intermediate credit banks.
- (3) Federal land banks.
- (4) Central bank for cooperatives.
- (5) Federal home loan banks, and stock thereof.
- (6) Federal national mortgage association, and stock thereof when acquired in connection with sale of mortgage loans to such association.
- (7) Any other similar agency of the government of the United States of America and of similar financial quality.

History.

1961, ch. 330, § 145, p. 645.

STATUTORY NOTES

Cross References.

Bonds or notes secured by trust deed insured by federal housing administration, § 41-721.

Federal home loan bank securities made legal investments, § 68-404.

Compiler's Notes.

The commodity credit corporation (CCC) is a government-owned and operated entity that was created to stabilize, support, and protect farm income and prices. CCC also helps maintain balanced and adequate supplies of agricultural commodities and aids in their orderly distribution.

CCC was incorporated October 17, 1933, under a Delaware charter. It was initially managed and operated in close affiliation with the

reconstruction finance corporation, which funded its operations.

On July 1, 1939, CCC was transferred to the United States Department of Agriculture (USDA). It was reincorporated on July 1, 1948, as a federal corporation within USDA by the commodity credit corporation charter act (62 Stat. 1070; 15 U.S.C. 714), as amended through P.L. 110-246, effective May 22, 2008.

For more information on the federal national mortgage association (Fannie Mae), see *<http://www.fanniemae.com/portal/index.html>*.

§ 41-709. Irrigation district bonds. — An insurer may invest in the legally issued bonds, not delinquent as to principal or interest, of any solvent irrigation district created as provided by law in this state, or in any other state, whose water rights shall have been legally acquired and finally determined, and shall be fully adequate to supply sufficient water to properly irrigate all the land within such district, and which shall be adequately irrigating not less than thirty per cent (30%) of the lands within such irrigation district.

History.

1961, ch. 330, § 146, p. 645.

§ 41-710. International bank. — An insurer may invest in obligations issued, assumed or guaranteed by the International Bank for Reconstruction and Development or the African Development Bank.

History.

1961, ch. 330, § 147, p. 645; am. 1988, ch. 240, § 1, p. 469.

STATUTORY NOTES

Compiler's Notes.

The International Bank for Reconstruction and Development is one of the five international organizations that make up the World Bank Group. See *<http://www.worldbank.org>*.

The African Development Bank was established in 1964 to promote economic and social justice in Africa. See *<http://www.afdb.org>*.

§ 41-711. Corporate obligations. — An insurer may invest any of its funds in obligations other than those eligible for investment under [section 41-721, Idaho Code](#), (mortgage loans and contracts), if they are issued, assumed, or guaranteed by any solvent institution created or existing under the laws of the United States or of any state, district or territory thereof, or of the government of Canada or any province thereof, and if said institution is not in default as to principal or interest on any of its obligations.

History.

1961, ch. 330, § 148, p. 645; am. 1969, ch. 214, § 18, p. 625; am. 1978, ch. 142, § 1, p. 322; am. 1983, ch. 189, § 3, p. 510.

STATUTORY NOTES

Cross References.

Common stocks, § 41-714.

Insurance stocks, § 41-715.

Preferred stocks, § 41-713.

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-712. Certain terms defined. — (1) Certain terms used are defined for the purposes of this chapter as follows:

- (a) “Obligation” includes bonds, debentures, notes or other evidences of indebtedness.
- (b) “Institution” includes corporations, joint-stock associations, and business trusts.

History.

1961, ch. 330, § 149, p. 645; am. 1969, ch. 214, § 19, p. 625.

STATUTORY NOTES

Compiler’s Notes.

As amended by S.L. 1969, Chapter 214, this section has a subsection (1), but no subsection (2).

§ 41-713. Preferred stocks — Diversification. — An insurer may invest any of its funds, in an aggregate amount not exceeding fifteen percent (15%) of its assets in preferred stocks or shares, other than common stocks, of solvent institutions existing under the laws of the United States or of any state, district, or territory thereof, or of the government of Canada or any province thereof, if all of the prior obligations and prior preferred stocks, if any, of such institution at the date of acquisition by the insurer are not then in default as to principal, interest or dividends.

History.

1961, ch. 330, § 150, p. 645; am. 1969, ch. 214, § 20, p. 625; am. 1983, ch. 189, § 4, p. 510; am. 2006, ch. 27, § 1, p. 86.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 27, deleted “and guaranteed” following “Preferred” in the section heading; and, in the section, deleted “or guaranteed” following “assets in preferred” and inserted “or of the government of Canada or any province thereof”.

§ 41-714. Common stocks. — After satisfying the requirements of section 41-706(3) and (4), Idaho Code, (investment of capital and life reserves), an insurer may invest funds in an aggregate amount not in excess of fifteen percent (15%) of its assets in common shares of stock of any solvent institution existing under the laws of the United States or of any state, district or territory thereof, or of the government of Canada or any province thereof, that qualify as a sound investment, in addition to the shares of a substantially owned or wholly owned subsidiary corporation.

For the purpose of determining the investment limitation imposed by this section, the insurer shall value securities subject to the provisions of this section at the cost of the security or at the market value of the security, whichever is lower. However, investments in the shares of subsidiaries or companion insurance companies shall be governed by sections 41-715 and 41-3803, Idaho Code.

The limitations as to investment in common stocks as provided herein shall not apply to nor limit the right of investments in investment trust securities as provided for in [section 41-716, Idaho Code](#).

History.

1961, ch. 330, § 151, p. 645; am. 1969, ch. 214, § 21, p. 625; am. 1971, ch. 122, § 5, p. 408; am. 1993, ch. 194, § 8, p. 492; am. 2003, ch. 219, § 2, p. 566; am. 2006, ch. 27, § 2, p. 86; am. 2013, ch. 266, § 4, p. 652.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 27, substituted “of the government of Canada or any province thereof” for “a foreign corporation publicly traded on United States stock exchanges” near the end of the first paragraph.

The 2013 amendment, by ch. 266, updated a reference in the second paragraph in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-715. Insurance stocks. — (1) An insurer may invest in subsidiary and/or companion insurance companies not to exceed fifteen percent (15%) of assets. For the purpose of calculating this fifteen percent (15%) limitation, all investments made under this section and [section 41-3803, Idaho Code](#), must be valued at market value of the security if actively traded, or at cost if not actively traded.

(2) The limitations on investments in insurance stocks set forth in this section shall not apply to stocks acquired under a plan for merger of the insurers which has been approved by the director or as to shares received as stock dividends upon shares already owned.

(3) Shares acquired and held under this section shall not, for the purposes of the limitations provided under [section 41-714, Idaho Code](#), be included among other common stocks held by the insurer.

History.

1961, ch. 330, § 152, p. 645; am. 1969, ch. 214, § 22, p. 625; am. 1983, ch. 189, § 5, p. 510; am. 1993, ch. 194, § 9, p. 492; am. 2013, ch. 266, § 5, p. 652.

STATUTORY NOTES

Cross References.

Investments in own capital stock prohibited, § 41-731.

Amendments.

The 2013 amendment, by ch. 266, updated a reference in subsection (1) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date

of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-716. Investment trust securities. — (1) An insurer may invest in the securities of any open-end management type investment company or investment trust registered with the federal securities and exchange commission under the investment company act of 1940 as from time to time amended, if such investment company or trust has been organized for not less than three (3) years and has assets of not less than twenty-five million dollars (\$25,000,000) as at the date of investment by the insurer. The aggregate amount invested under this section shall not exceed twenty-five percent (25%) of the insurer's assets with limitations of five percent (5%) of the insurer's assets in any one (1) fund and ten percent (10%) of the insurer's assets in any one (1) fund family.

(2) For the purpose of determining the investment limitation imposed by this section, the insurer shall value securities subject to the provisions of this section at the cost of the security or at the market value of the security, whichever is lower.

History.

1961, ch. 330, § 153, p. 645; am. 1983, ch. 189, § 6, p. 510; am. 1997, ch. 226, § 1, p. 664; am. 2003, ch. 219, § 3, p. 566; am. 2014, ch. 97, § 26, p. 265.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 97, made capitalization changes in subsection (1) and minor stylistic changes in subsection (2).

Federal References.

The investment company act of 1940, referred to in subsection (1), is compiled as [15 U.S.C.S. § 80a-1 et seq.](#)

Compiler's Notes.

For further information on the federal securities and exchange commission, referred to in subsection (1), see <https://www.sec.gov/>.

§ 41-717. Equipment trust obligations. — An insurer may invest any of its funds, in an aggregate amount not exceeding ten per cent (10%) of its assets, in equipment trust obligations or certificates which are adequately secured or in other adequately secured instruments evidencing an interest in transportation equipment wholly or in part within the United States and the right to receive determined portions of rental, purchase or other fixed obligatory payments for the use or purchase of such transportation equipment.

History.

1961, ch. 330, § 154, p. 645.

§ 41-718. Policy loans. — A life insurer may lend to its policy holder upon pledge of the policy as collateral security, any sum not exceeding the cash surrender value of the policy; or may lend against pledge or assignment of any of its supplementary contracts or other contracts or obligations, so long as the loan is adequately secured by such pledge or assignment. Loans so made are eligible investments of the insurer.

History.

1961, ch. 330, § 155, p. 645.

§ 41-719. Collateral loans. — An insurer may lend and thereby invest its funds upon the pledge of securities eligible for investment under this chapter. As at date made, no such loan shall exceed in amount ninety per cent (90%) of the market value of such collateral pledged. The amount so loaned shall be included pro rata in determining the maximum percentage of funds permitted under this chapter to be invested in the respective categories of securities so pledged.

History.

1961, ch. 330, § 156, p. 645.

§ 41-720. Savings and share accounts. — An insurer may invest or deposit any of its funds in time certificates or share or savings accounts of banks, savings and loan associations and credit unions; provided, however, that funds may be deposited in any one (1) such savings and loan association or credit union only to the extent that such an account is insured by either the federal savings and loan insurance corporation or the national credit union [share] insurance fund.

History.

1961, ch. 330, § 157, p. 645; am. 1971, ch. 122, § 6, p. 408; am. 1982, ch. 212, § 1, p. 586.

STATUTORY NOTES

Compiler's Notes.

The federal savings and loan insurance corporation, referred to near the end of the section, was abolished in 1989 and its insurance responsibilities were transferred to the federal deposit insurance corporation, see <https://www.fdic.gov/>.

The bracketed insertion near the end of the section was added by the compiler to correct the name of the referenced fund. The national credit union share insurance fund is administered by the national credit union administration. See <https://www.ncua.gov/services/Pages/share-insurance.aspx>.

§ 41-721. Mortgage loans and contracts. — An insurer may invest any of its funds in:

(1) Bonds or evidences of debt which are secured by first mortgages or deeds of trust on improved unencumbered real property located in the United States.

(2) Purchase money mortgages or like securities received by it upon the sale or exchange of real property acquired pursuant to [section 41-728, Idaho Code](#).

(3) Bonds or notes secured by mortgage or trust deed guaranteed or insured by the federal housing administration under the terms of an act of congress of the United States for June twenty-seventh, nineteen hundred thirty-four, entitled the “National Housing Act,” as amended.

(4) Bonds or notes secured by mortgage or trust deed guaranteed or insured as to principal in whole or in part by the administrator of veterans affairs pursuant to the provisions of title III of an act of congress of the United States of June twenty-second, nineteen hundred forty-four, entitled the “Servicemen’s Readjustment Act of 1944,” as amended, or by any other similar agency of the government of the United States.

(5) Evidences of debt secured by first mortgages or deeds of trust upon leasehold estates, running for a term of not less than fifteen (15) years beyond the maturity of the loan as made or as extended, in improved real property, otherwise unencumbered, and if the mortgagee is entitled to be subrogated to all the rights under the leasehold.

(6) Bonds or notes secured by mortgage and insured by mortgage guarantee insurance as provided by chapter 26A, title 41, Idaho Code.

(7) Participation interests in any bond, note or evidence of indebtedness if the entire indebtedness would qualify as an investment under subsections (1) through (6) of this section, and:

(a) Such participation is senior and gives the holder substantially the rights of a first mortgagee; or

(b) Such participation is of equal priority, to the extent of such interest, with other interests therein.

History.

1961, ch. 330, § 158, p. 645; am. 1969, ch. 214, § 23, p. 625; am. 1974, ch. 91, § 2, p. 1187; am. 2003, ch. 163, § 1, p. 459; am. 2006, ch. 26, § 1, p. 84.

STATUTORY NOTES

Cross References.

Federal housing administration and national mortgage associations, securities of, made legal investments, § 68-402.

Housing authority bonds made legal investments, § 68-405.

Loans on real estate insured by federal housing administration, § 68-401.

Amendments.

The 2006 amendment, by ch. 26, deleted former subsection (2) which read: “The equity of the seller of any such property in the contract for a deed, covering the entire balance due on a bona fide sale of such property, in an amount not to exceed ten thousand dollars (\$10,000) or the amount permissible under [section 41-706, Idaho Code](#), whichever is greater, in any one (1) such contract for deed; nor in any amount in excess of seventy-five percent (75%) of the actual sale price or fair value of the property, whichever is the smaller”; redesignated former subsections (3) to (8) as present subsections (2) to (7); and substituted “(6)” for “(7)” in present subsection (7).

Federal References.

The National Housing Act is compiled as [12 U.S.C.S. § 1701 et seq.](#)

The Servicemen’s Readjustment Act of 1944, referred to in subsection (4), was classified as [38 USCS § 693 et seq.](#) and was repealed by Acts June 17, 1957, [P.L. 85-56](#), Title XXII, § 2202(128), (176), [71 Stat. 167](#), 170, and Sept. 2, 1958, [P.L. 85-857](#), § 14(87), [72 Stat. 1273](#). Similar provisions are contained in [38 USCS § 3701 et seq.](#) The federal department of veterans affairs is now headed by the secretary of veterans affairs.

§ 41-722. Mortgage loan limited by property value. — (1) No commercial or residential mortgage loan or investment therein upon any one (1) parcel of real property shall exceed in amount, at the time of acquisition, eighty percent (80%) of the fair value of the property and the loan is required to be amortized within not more than thirty (30) years by payment of installments of principal and interest thereon at regular intervals not less frequent than every year.

(2) The extent to which a mortgage loan made under subsection (3) or (4) of [section 41-721, Idaho Code](#), is guaranteed by the administrator [secretary] of veterans affairs may be deducted before application of the limitations contained in subsection (1) of this section.

History.

1961, ch. 330, § 159, p. 645; am. 1969, ch. 214, § 24, p. 625; am. 2002, ch. 364, § 1, p. 1027; am. 2006, ch. 26, § 2, p. 84.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 26, deleted former subsection (1) which read: “No commercial mortgage loan or investment therein upon any one (1) parcel of real property shall exceed in amount, at the time of acquisition, seventy-five percent (75%) of the fair value of the property and the loan is required to be amortized within not more than thirty (30) years by payment of installments of principal and interest thereon at regular intervals not less frequent than every year”; redesignated former subsections (2) and (3) as present subsections (1) and (2); inserted “commercial or” near the beginning of present subsection (1); and substituted “(3) or (4)” for “(4) or (5)” in present subsection (2).

Compiler’s Notes.

The bracketed insertion in subsection (2) was added by the compiler to reflect the 1989 creation of the federal department of veterans affairs, headed by a secretary. See <https://www.va.gov/>.

CASE NOTES

Cited Hayden Lake Fire Prot. Dist. v. Alcorn, 141 Idaho 388, 111 P.3d 73 (2005).

§ 41-723. Appraisal — Limit of amount loaned. — (1) The fair value of property shall be determined by appraisal by a competent independent appraiser at the time of the making or acquisition of a mortgage loan or investing in a contract for the deed thereon; except, that as to bonds or notes secured by mortgage or trust deed guaranteed or insured by the federal housing administration, or guaranteed or insured as to principal in full or in part by the administrator [secretary] of veterans affairs, or guaranteed or insured by the farmers home administration, the valuation made by such administration or administrator shall be deemed to have been made by a competent appraiser for the purposes of this subsection.

(2) An insurer shall not make or acquire a loan or loans upon the security of any one (1) parcel of real property in aggregate amount in excess of ten thousand dollars (\$10,000) or more than the amount permissible under [section 41-706\(1\), Idaho Code](#), (investment in securities, etc., of any one person), whichever is the greater.

History.

1961, ch. 330, § 160, p. 645; am. 2003, ch. 219, § 4, p. 566.

STATUTORY NOTES

Federal References.

Farmers home administration, [7 USCS § 1981 et seq.](#)

Compiler's Notes.

The federal housing administration is a part of the department of housing and urban development and insures mortgages on various type of homes and hospitals for qualified buyers. See <https://www.hud.gov/programoffices/uhousing/fhahistory>.

The bracketed insertion near the end of subsection (1) was added by the compiler to reflect the 1989 creation of the federal department of veterans affairs, headed by a secretary. See <https://www.va.gov>.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-724. “Improved real property” defined. — For the purpose of section 41-724 [41-721], Idaho Code, “improved real property” means:

(1) Farmland used for tillage, crop or pasture; (2) Real estate on which improvements, or improvements under construction or in process of construction, suitable for residence, institutional, commercial or industrial use, are situated; and (3) Real estate to be developed for the use or uses set forth in subsection (2) of this section on which durable structural improvements, or durable structural improvements under construction or in process of construction, including but not limited to streets, sidewalks, sewers, and utilities which will become an integral part of such development, are situated or abut.

History.

I.C., § 41-724, as added by 1974, ch. 91, § 4, p. 1187.

STATUTORY NOTES

Prior Laws.

Former § 41-724 which comprised S.L. 1961, ch. 330, § 161, p. 645, was repealed by S.L. 1974, ch. 91, § 3.

Compiler’s Notes.

The bracketed insertion in the introductory paragraph was added by the compiler to supply the probable intended reference.

§ 41-725. “Encumbrance” defined. — (1) Real property shall not be deemed to be encumbered within the meaning of section 41-721[, Idaho Code,] by reason of the existence of instruments reserving mineral, oil, timber or similar rights, rights of way, sewer rights, rights in walls, nor by reason of any liens for taxes or assessments not yet due, or on account of liens not delinquent for community recreational facilities, or for the maintenance of community facilities, nor by reason of building restrictions or other restrictive covenants common to the community in which the property is located, nor by liens for service and maintenance of water rights where not delinquent, nor when such real property is subject to lease under which rents or profits are reserved to the owner if in any event the security for the loan or investment is a first lien upon the real property.

(2) If under any of the exceptions set forth in subsection (1) of this section there is any sum owing but not due or delinquent, the total amount of such sum shall be deducted from the amount which otherwise might be loaned on the property. The value of any mineral, oil, timber or similar right reserved shall not be included in the fair value of the property.

History.

1961, ch. 330, § 162, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertion near the beginning of subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-726. Special investments by title insurer. — (1) In addition to other investments eligible under this chapter, a title insurer may invest in its abstract plant and equipment, and in loans secured by mortgages on abstract plants and equipment, which plant investment shall not exceed fifty per cent (50%) of its paid-in capital stock and paid-in surplus unless a greater amount is approved in advance by the director. Except with the director's consent, the insurer shall not invest or have invested in stocks of subsidiaries and other corporate stocks an amount in excess of the insurer's surplus funds exclusive of its paid-in capital stock.

(2) In any determination of the insurer's financial condition no investment in abstract plant and equipment, or in loans secured by mortgages thereon, shall be valued at an amount in excess of the lesser of (a) the cost thereof to the insurer, or (b) the fair market value.

(3) No investment as determined in subparagraph (2) above shall be credited against the insurer's unearned premium or loss reserves required under [section 41-611, Idaho Code](#).

History.

1961, ch. 330, § 163, p. 645; am. 1972, ch. 138, § 1, p. 305.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-727. Foreign securities. — (1) Notwithstanding the definitions in chapter 1, title 41, Idaho Code, for purposes of this section, the following definitions shall apply:

(a) “Business entity” means a sole proprietorship, corporation, limited liability company, association, partnership, joint stock company, joint venture, mutual fund, trust, joint tenancy or other similar form of business organization, whether organized for-profit or not-for-profit.

(b) “Domestic jurisdiction” means the United States, Canada, and a state or political subdivision of the United States or Canada.

(c) “Foreign currency” means a currency other than that of the United States or Canada.

(d) “Foreign investment” means an investment in a foreign jurisdiction or in an asset domiciled in a foreign jurisdiction. An investment shall not be deemed to be foreign if the issuing business entity, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a business entity domiciled in a domestic jurisdiction, unless:

(i) The issuing business entity is a shell business entity; and

(ii) The investment is not assumed, accepted, guaranteed or insured or otherwise backed by a domestic jurisdiction or a business entity that is not a shell business entity domiciled in a domestic jurisdiction.

(e) “Foreign jurisdiction” means a jurisdiction outside of the United States or Canada.

(f) “Qualified guarantor” means a guarantor against which an insurer has a direct claim for full and timely payment evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(g) “Qualified primary credit source” means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim for full and timely payment evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(h) “Shell business entity” means a business entity having no economic substance except as a vehicle for owning interests in assets issued, owned or previously owned by a business entity domiciled in a foreign jurisdiction.

(i) “SVO” means the securities valuation office of the national association of insurance commissioners or any successor office established by the national association of insurance commissioners.

(2) Any insurance company organized under any law of this state may invest, by loans or otherwise, any of its funds, or any part thereof, in foreign investments of the same types as those that an insurer is permitted to acquire under sections 41-707, 41-708, 41-711, 41-713, 41-714, 41-716 and 41-721(1), Idaho Code, if:

(a) The aggregate amount of foreign investments then held by the insurer does not exceed fifteen percent (15%) of its admitted assets; and

(b) The aggregate amount of foreign investments then held by the insurer in a single foreign jurisdiction does not exceed ten percent (10%) of its admitted assets for jurisdictions that have a sovereign debt rating of SVO 1, or three percent (3%) of its admitted assets for all other jurisdictions.

(3) Any insurance company organized under any law of this state may invest, by loans or otherwise, any of its funds, or any part thereof, in investments of the same types as those that an insurer is permitted to acquire under sections 41-707, 41-708, 41-711, 41-713, 41-714, 41-716 and 41-721(1), Idaho Code, which are denominated in foreign currencies, whether or not they are foreign investments acquired under subsection (2) of this section, if:

(a) The aggregate amount of investments then held by the insurer denominated in foreign currencies does not exceed ten percent (10%) of its admitted assets; and

(b) The aggregate amount of investments then held by the insurer denominated in the foreign currency of a single foreign jurisdiction does not exceed five percent (5%) of its admitted assets for jurisdictions that have a sovereign debt rating of SVO 1, or three percent (3%) of its admitted assets for all other jurisdictions.

(4) The investment limitations in subsections (2) and (3) of this section computed on the basis of an insurer's admitted assets shall relate to the amount as shown on the insurer's last annual report as filed with the commissioner of insurance or a more recent quarterly financial statement as filed with the commissioner, on a form prescribed by the national association of insurance commissioners, within forty-five (45) days following the end of the calendar quarter to which the interim statement pertains.

(5) Investments acquired under this section shall be aggregated with investments of the same types made under sections 41-707, 41-708, 41-711, 41-713, 41-714, 41-716 and 41-721(1), Idaho Code, and in a similar manner, for purposes of determining compliance with the limits, if any, contained in this chapter.

History.

I.C., § 41-727, as added by 2006, ch. 27, § 4, p. 86.

STATUTORY NOTES

Cross References.

Annual statement, § 41-335.

Prior Laws.

Former § 41-727, which comprised 1961, ch. 330, § 164, p. 645 and related to foreign securities, was repealed by S.L. 2006, ch. 27, § 3.

Compiler's Notes.

As to the securities valuation office of the national association of insurance commissioners, referred to in paragraphs (1)(i), (2)(b) and (3)(b), see <http://naic.org/svo.htm>.

§ 41-728. Real estate. — (1) An insurer may acquire, invest in, own, maintain, alter, furnish, improve, manage, lease and convey the following real estate only:

(a) Land and buildings used for home office purposes, including contiguous parcels intended for future home office or corporate campus expansion, together with such other real estate as is required for its accommodation in the convenient transaction of its business.

(b) Real estate acquired in satisfaction in full or in part of or through foreclosure of or judgment obtained upon, loans, mortgages, liens or other evidences of indebtedness previously owing to the insurer in the regular course of its business.

(c) Real estate acquired in part payment of the consideration in the sale of other real estate owned by the insurer.

(d) Real estate acquired by gift or devise.

(e) Real estate acquired through a lawful merger or consolidation of another insurer and not required for its accommodation as provided in paragraph (a) of this subsection.

(f) Real estate for the production of income, under lease, or being constructed under a definite agreement providing for lease, to solvent institutions for commercial or industrial purposes, other than primarily for agricultural, horticultural, ranch, mining, mineral, oil, recreational, amusement, club, motel, or hotel purposes.

(g) Real estate subject to a plan of development other than primarily for agricultural, horticultural, ranch, mining, mineral, oil, recreational, amusement, club, motel, or hotel purposes as limited by subsection (2)(c) of this section.

(2) The aggregate amount so invested by the insurer shall not exceed:

(a) If for home office and its other purposes pursuant to subsection (1)(a) of this section, fifteen percent (15%) of the insurer's assets, subject to the right of the director to approve an additional amount after hearing and for good cause shown.

(b) If for income purposes pursuant to subsection (1)(f) of this section, ten percent (10%) of the insurer's admitted assets.

(c) If for properties subject to a plan of development pursuant to subsection (1)(g) of this section, not more than five percent (5%) of its admitted assets of which not more than two percent (2%) of its admitted assets may be in any one (1) parcel or group of contiguous parcels. The director may disapprove the property as an admitted asset if the plan of development is not being pursued in good faith. Factors for review may include, but are not limited to, progress with regard to zoning, roads, utilities, plats and completed development by the insurer of properties.

(d) In all categories and for all purposes, not to exceed twenty percent (20%) of the insurer's assets.

(3) An insurer may lease to others part of real property otherwise occupied by it for home office and other purposes under subsection (1)(a) of this section, but the value of the entire property must be included for the purposes of the limitation upon aggregate real estate investments provided in subsection (2)(a) of this section.

History.

1961, ch. 330, § 165, p. 645; am. 2001, ch. 174, § 1, p. 594; am. 2002, ch. 364, § 2, p. 1027; am. 2009, ch. 49, § 1, p. 129; am. 2019, ch. 112, § 2, p. 369.

STATUTORY NOTES

Amendments.

The 2009 amendment, by ch. 49, deleted subsection (2)(e), which specified the maximum aggregate amount of real estate that may be invested by certain insurers.

The 2019 amendment, by ch. 112, inserted “including contiguous parcels intended for future home office or corporate campus expansion” in paragraph (1)(a); and substituted “fifteen percent (15%)” for “ten percent (10%)” in paragraph (2)(a).

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Decisions Under Prior Law

Insurance Companies Engaged in Loan Business.

Certain statutes of Idaho expressly countenanced, sanctioned, and made certain concessions to insurance companies loaning money in the state, thus recognizing that loaning money is a concomitant part of the business of an insurance company. *Union Cent. Life Ins. Co. v. Rahn*, 63 Idaho 243, 118 P.2d 717 (1941).

§ 41-729. Time limit for disposal of real estate. — (1) Except as provided in subsection (4) below, an insurer shall dispose of real estate within time limits as follows:

(a) If acquired under section 41-728(1)(a)[, Idaho Code] (home office and branch office property), the insurer shall sell and dispose of the property within five (5) years after it ceased to be used or to be necessary for the purposes stated therein.

(b) If acquired under subdivisions (b) (in satisfaction of debts, etc.), (c) (in part payment on other real estate sold), (d) (by gift or devise), or (e) (merger or consolidation) of section 41-728(1)[, Idaho Code], the insurer shall sell and dispose of the property within five (5) years after the insurer acquired title thereto.

(c) If acquired under section 41-728(1)(f)[, Idaho Code] (for production of income), the insurer shall within five (5) years after the termination or expiration of the lease, sell and dispose of the property, or re-lease the property for an additional term under the same conditions provided in such section as for an original leasing.

(2) Any real estate otherwise subject to disposal under subdivisions (b) or (c) above, may be retained by the insurer for home office or branch office purposes for so long as so used, and subject to provisions otherwise applicable to such home office and branch office property.

(3) Any real property otherwise subject to disposal under subdivisions (a) and (b) above, may be retained by the insurer for leasing under section 41-728(1)(f)[, Idaho Code,] for so long as so used, and subject to provisions otherwise applicable to such real estate for leasing.

(4) Upon proof satisfactory to him that the interests of the insurer will suffer materially by the forced sale thereof, the commissioner may by certificate grant a reasonable additional period, as specified in the certificate, within which the insurer shall dispose of any particular parcel of real estate.

(5) Real estate held by an insurer beyond the period allowed for its disposal under this section shall not constitute an asset of the insurer in any

determination of the insurer's financial condition.

History.

1961, ch. 330, § 166, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in paragraphs (1)(a), (1)(b), and (1)(c) and subsection (3) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-730. Disposal of ineligible property and securities. — (1) Any personal property or securities lawfully acquired by an insurer which it could not otherwise have invested in or loaned its funds upon at the time of such acquisition, shall be disposed of by the insurer within one (1) year from date of acquisition, unless within such period the security has attained to the standard for eligibility. The director, upon application and proof that forced sale of any such property or security would be against the best interests of the insurer, may extend the disposal period for an additional reasonable time.

(2) While any such property or security remains so ineligible it shall not be allowed as an asset of the insurer.

(3) Any ineligible property or security unlawfully acquired by an insurer shall be disposed of forthwith, and for failure so to do within thirty (30) days after order of the director requiring such disposal, the director may suspend or revoke the insurer's certificate of authority.

(4) For the purposes of subsection (3) above, an investment otherwise eligible shall not be deemed ineligible for the reason that it is in excess of the amount permitted under this chapter to be invested in the category of investments to which it belongs; and any such excess investment shall be disposed of within the time prescribed in subsection (1) of this section.

History.

1961, ch. 330, § 167, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-731. Prohibited investments and investment underwriting. —

(1) In addition to investments excluded under other provisions of this code, an insurer shall not directly or indirectly invest in or loan its funds upon the security of:

(a) Issued shares of its own capital stock, except for the purpose of mutualization under [section 41-2854, Idaho Code](#), or in connection with a plan approved by the director for purchase of such shares by the insurer's officers, employees, or agents, or for other reasonable purposes under a plan filed with and approved by the director. No such stock shall, however, constitute an asset of the insurer in any determination of its financial condition.

(b) Except with the director's consent, any security issued by any corporation or enterprise the controlling interest of which is, or will after such acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries, controlling stockholders, and the spouses and children of any of the foregoing individuals. Investments in subsidiaries under sections 41-706(2), 41-715 and 41-3803, Idaho Code, shall not be subject to this provision.

(c) Any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the insurer, or the spouse or child of any of the foregoing individuals, except as to policy loans authorized under [section 41-718, Idaho Code](#).

(d) Any investment or security which is found by the director to be designed to evade any prohibition of this chapter.

(2) No insurer shall underwrite or participate in the underwriting of an offering of securities or property by any other person.

History.

1961, ch. 330, § 168, p. 645; am. 1969, ch. 214, § 25, p. 625; am. 1971, ch. 122, § 7, p. 408; am. 1993, ch. 194, § 10, p. 492; am. 2013, ch. 266, § 6, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated a reference in paragraph (1) (b) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-732. Domestic reciprocal insurer. — Notwithstanding the provisions of chapter 1, title 57, Idaho Code, and [section 67-2328, Idaho Code](#), funds of a domestic reciprocal insurer which is comprised of and exclusively insures members who are political subdivisions of the state, as defined in [section 6-902\(2\), Idaho Code](#), and which exclusively insures against risk pertaining to property and casualty claims, shall be invested, reinvested and used in the manner and subject to the conditions, restrictions and limitations set forth in this chapter.

History.

[I.C., § 41-732](#), as added by 2008, ch. 399, § 1, p. 1089.

STATUTORY NOTES

Prior Laws.

Former § 41-732, which comprised 1961, ch. 330, § 169, p. 645, was repealed by S.L. 1994, ch. 240, § 4, effective March 30, 1994.

§ 41-733. Subsidiary investments. — An insurer may invest in subsidiaries in accordance with [section 41-3803, Idaho Code](#).

History.

[I.C., § 41-733](#), as added by 1969, ch. 214, § 26, p. 625; am. 1971, ch. 122, § 8, p. 408; am. 1974, ch. 91, § 5, p. 1187; am. 1983, ch. 189, § 7, p. 510; am. 1993, ch. 194, § 11, p. 492; am. 2013, ch. 266, § 7, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated the statutory reference in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Compiler's Notes.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

Section 37 of S.L. 1993, ch. 194 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

§ 41-734. Separate account funds. — (1) The amounts allocated to each separate account established by the insurer pursuant to any provision of the Idaho Insurance Code (separate accounts), together with accumulations thereon may be invested and reinvested in any class of investments which may be authorized in the written contract or agreement without regard to any requirements or limitations prescribed by this chapter. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the insurer.

(2) Except with the approval of the director and under such conditions as to investments and other matters as he may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for (a) benefits guaranteed as to dollar amount and duration and (b) funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account.

History.

I.C., § 41-734, as added by 1969, ch. 214, § 27, p. 625; am. 1971, ch. 272, § 1, p. 1078.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-735. Miscellaneous investments. — (1) An insurer may loan or invest its funds in kinds of loans or investments not otherwise specifically made eligible for investment and not specifically prohibited or made ineligible by this or other provisions of the Idaho Code in an aggregate amount not exceeding the lesser of ten percent (10%) of an insurer's assets, or seventy-five percent (75%) of an insurer's capital and surplus excluding surplus notes. Investments under this subsection are limited to five percent (5%) of an insurer's assets in a single investment or in a single entity, its affiliates, and subsidiaries as defined by the first six (6) digits of the committee on uniform security identification procedures (CUSIP) number.

(2) The insurer shall keep a separate record of all investments acquired under this section.

History.

I.C., § 41-735, as added by 1975, ch. 207, § 2, p. 575; am. 1983, ch. 189, § 8, p. 510; am. 2019, ch. 112, § 3, p. 369.

STATUTORY NOTES

Amendments.

The 2019 amendment, by ch. 112, rewrote subsection (1), which formerly read: "An insurer may loan or invest its funds in an aggregate amount not exceeding the lesser of the following sums: five per cent (5%) of its assets, or fifty per cent (50%) of its surplus over its capital and other liabilities, or if a mutual or reciprocal insurer fifty per cent (50%) of its surplus over minimum required surplus, in kinds of loans or investments not otherwise specifically made eligible for investment and not specifically prohibited or made ineligible by this or other provisions of the Idaho Code."

Compiler's Notes.

The abbreviation enclosed in parentheses so appeared in the law as enacted.

§ 41-736. Permitted investments. — Subject to other limitation in chapter 7, title 41, Idaho Code, an insurer shall not invest or have invested at any one time more than sixty-five percent (65%) of its assets in investments described in sections 41-721 and 41-728, Idaho Code. Any insurer which, on July 1, 2003, has in excess of sixty-five percent (65%) of its assets so invested shall not make any further such investments while the excess exists. The limitations prescribed in this section shall not apply to mortgage-backed securities rated one or two by the securities valuation office (SVO) of the national association of insurance commissioners or to mortgage-backed securities which qualify as provisionally exempt from filing with the SVO.

History.

I.C., § 41-736, as added by 2003, ch. 163, § 2, p. 459.

STATUTORY NOTES

Compiler's Notes.

As to the securities valuation office of the national association of insurance commissioners, referred to in this section, see *<http://naic.org/svo.htm>*.

Chapter 8

ADMINISTRATION OF DEPOSITS

Sec.

41-801. Authorized deposits of insurers.

41-802. Purpose of deposit.

41-803. Securities eligible for deposit.

41-804. Custodial arrangements for deposits.

41-805. Records — Certificate of deposit.

41-806. Assignment of securities.

41-807. Appraisal.

41-808. Excess deposits.

41-809. Rights of insurer during solvency.

41-810. Levy upon deposit.

41-811. Deficiency of deposit.

41-812. Duration and release of deposit.

41-813. Proofs for release of deposit to insurer — Director's responsibility.

§ 41-801. Authorized deposits of insurers. — The following deposits of insurers when made through the director shall be accepted and held, and shall be subject to the applicable provisions of this chapter:

(1) Deposits required under this code for authority to transact insurance in this state.

(2) Deposits of domestic insurers when made pursuant to the laws of other states, provinces and countries as requirement for authority to transact insurance in such state, province or country.

(3) Deposits in such additional amounts as are permitted to be made under section 41-808[, Idaho Code,] (excess deposits).

History.

1961, ch. 330, § 170, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of subsection (3) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-802. Purpose of deposit. — Such deposits shall be held for purposes as follows:

(1) Deposits made in this state under [sections 41-316, Idaho Code](#), (foreign and alien insurance deposit requirements), and 41-316A, Idaho Code, (domestic insurance deposit requirements), shall be held for the purposes stated in the respective sections.

(2) A deposit made in this state by a domestic insurer transacting insurance in another state, province or country, and as required by the laws of such state, province or country, shall be held for the purpose or purposes specified pursuant to such laws.

(3) Deposits of foreign insurers required pursuant to the retaliatory provision, [section 41-340, Idaho Code](#), shall be held for such purposes as are required by such law, and as specified by the director's order by which the deposit is required.

History.

1961, ch. 330, § 171, p. 645; am. 1994, ch. 240, § 8, p. 751; am. 2004, ch. 90, § 4, p. 325.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner’s” has been changed to “director’s” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance

with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-803. Securities eligible for deposit. — (1) All such deposits required under sections 41-316 and 41-316A, Idaho Code, for authority to transact insurance in this state shall consist of certificates of deposit issued by solvent banks, or any combination of securities the market value of which is readily ascertainable and, if negotiable by delivery or assignment, of the kinds described in the following sections:

- (a) Section 41-707[, Idaho Code] (public obligations);
- (b) Section 41-708[, Idaho Code] (securities of certain federal agencies);
- (c) Section 41-709[, Idaho Code] (irrigation district obligations); (d) Section 41-710[, Idaho Code] (international bank);
- (e) Section 41-711[, Idaho Code] (corporate obligations); (f) Section 41-717[, Idaho Code] (equipment trust obligations); and (g) Section 41-720[, Idaho Code] (savings and share accounts).

(2) Except that the director shall accept as a security eligible for deposit and recognize as part of the deposit any particular valid and enforceable real estate mortgage already lawfully so on deposit at the effective date of this code, so long as the mortgage continues to qualify for investment of the insurer's funds therein as under chapter 7[, title 41, Idaho Code,] of this code and is not in default in any particular.

(3) All such deposits required of a domestic insurer pursuant to the laws of another state, province or country shall be comprised of securities, if negotiable by delivery or assignment, of the kind or kinds required or permitted by the laws of such state, province or country, except stocks, mortgages of any kind and real estate.

(4) Deposits of foreign insurers made in this state under the retaliatory provision, [section 41-340, Idaho Code](#), shall consist of such securities or assets as are required by the director pursuant to such provision.

History.

1961, ch. 330, § 172, p. 645; am. 1994, ch. 240, § 9, p. 751; am. 2004, ch. 90, § 5, p. 325.

STATUTORY NOTES

Cross References.

Federal home loan bank securities made legal investments, § 68-404.

Federal housing administration and national mortgage associations, securities of made legal investments, § 68-402.

Housing authority bonds made legal investments, § 68-405.

Insurance of loans on real property and lease-holds, § 68-401.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in subsections (1) and (2) were added by the compiler to conform to the statutory citation style.

The phrase “the effective date of this code” in subsection (2) refers to the effective date of S.L. 1961, Chapter 330, which was effective January 1, 1962.

The words enclosed in parentheses so appeared in the law as enacted.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-804. Custodial arrangements for deposits. — (1) All deposits of insurers made in this state under this code shall be made through the director.

(2) The deposits shall be made with and held by the trust department of an established bank located in Idaho, approved by the director for the purpose, and under custodial arrangements likewise approved by him. All such custodial arrangements shall comply in substance with the requirements of this code as to the amount, purposes, maintenance, initial amounts, release and withdrawal of such a deposit, and as to the rights of the insurer therein.

(3) The securities qualified for deposit under this chapter may be deposited with a clearing corporation or held in the federal reserve book-entry system. Securities deposited with a clearing corporation or held in the federal reserve book-entry system and used to meet the deposit requirements set forth in this chapter shall be under the control of the director of the department of insurance and shall not be withdrawn by the insurer without the approval of the director. Any insurer holding securities in such manner shall provide evidence satisfactory to the director, issued by its custodian or member bank through which such insurer has deposited such securities in a clearing corporation or through which such securities are held in the federal reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank, and that the records of the custodian, other participant or member bank reflect that such securities are held subject to the order of the director. Definitions contained in [section 41-2870, Idaho Code](#), shall apply to this subsection (3).

(4) The cost of any such custodial arrangements shall be borne by the insurer. The state of Idaho shall have no responsibility for the safekeeping of the deposit.

History.

1961, ch. 330, § 173, p. 645; am. 1969, ch. 214, § 28, p. 625; am. 1981, ch. 174, § 3, p. 306; am. 2004, ch. 90, § 6, p. 325.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

For more on the federal reserve book-entry system, see *<https://www.newyorkfed.org/aboutthefed/fedpoint/fed05.html>*.

§ 41-805. Records — Certificate of deposit. — (1) The director shall maintain complete record of all securities deposited through him under this chapter, and of all transactions involving any such deposit.

(2) Upon request of the insurer and payment of the fee therefor required under section 41-401[, Idaho Code] (fee schedule), the director shall furnish to the insurer his certificate under his official seal certifying as to any deposit of the insurer held by him under this code, and as to the amount, composition, and purposes of the deposit.

History.

1961, ch. 330, § 174, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in subsection (2) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-806. Assignment of securities. — (1) The insurer shall duly assign to the director and his successors in office in trust all securities being deposited through him under this code which are not negotiable by delivery; or, in lieu of such assignment, the insurer may give the director an irrevocable power of attorney authorizing him to transfer the securities or any part thereof for any purpose within the scope of this chapter.

(2) Upon release to the insurer, or other person entitled thereto, of any such security the director shall reassign the same to such insurer or person; or, in the case of power of attorney given pursuant to subsection (1) above, he shall deliver the power of attorney, together with the securities covered thereby, to the insurer or person entitled thereto.

History.

1961, ch. 330, § 175, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-807. Appraisal. — The director may, in his discretion, prior to acceptance for deposit of any particular asset or security, or at any time thereafter while so deposited, have the same appraised or valued by competent appraisers. The reasonable costs of any such appraisal or valuation shall be borne by the insurer.

History.

1961, ch. 330, § 176, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-808. Excess deposits. — (1) If securities or assets deposited by an insurer under this chapter are subject to material fluctuations in market value, the director may, in his discretion, require the insurer to deposit and maintain on deposit additional securities or assets in such amount as may be reasonably necessary to assure that the deposit will at all times have a market value of not less than the amount specified under or pursuant to the law by which the deposit is required.

(2) If not so required by the director, an insurer may at its option so deposit assets or securities in an amount exceeding its deposit required or otherwise permitted under this code by not more than twenty per cent (20%) of such required or permitted deposit, or twenty thousand dollars (\$20,000), whichever is the larger amount, for the purpose of absorbing fluctuations in the value of securities and assets deposited, and to facilitate the exchange and substitution of such securities and assets. During the solvency of the insurer any such excess shall be released to the insurer upon its request. During the insolvency of the insurer, such excess deposit shall be released only as provided in section 41-812(2)(e)[, Idaho Code].

History.

1961, ch. 330, § 177, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of subsection (2) was added by the compiler to conform to the statutory citation style.

§ 41-809. Rights of insurer during solvency. — So long as the insurer remains solvent and is in compliance with this code it may:

(1) Demand, receive, sue for and recover the income from the securities or assets deposited; (2) Exchange and substitute for the deposited securities or assets, or any part thereof, other eligible securities and assets of equivalent or greater value; and (3) At any reasonable time inspect any such deposit.

History.

1961, ch. 330, § 178, p. 645.

§ 41-810. Levy upon deposit. — (1) No judgment creditor or other claimant of an insurer shall have the right to levy upon any of the assets or securities of the insurer held on deposit in this state pursuant to section 41-316 or 41-316A, Idaho Code.

(2) As to deposits made in this state pursuant to the retaliatory provision, [section 41-340, Idaho Code](#), levy thereupon shall be permitted only if expressly so provided in the director's order under which the deposit is required.

(3) As to the special deposit of a title insurer, if upon expiration of thirty (30) days after the judgment became final the insurer has failed to satisfy in full any final judgment rendered against it by a court of this state and arising out of any contract of insurance or guaranty issued by it, the judgment may be enforced against the insurer's deposit. For the purposes of this provision a judgment shall be deemed to have become final upon expiration of the period permitted by law for an appeal, or, if an appeal is taken, upon dismissal of the appeal or affirmance of the judgment.

(4) To obtain the enforcement referred to in subsection (3) of this section, the judgment creditor shall petition the court in the same cause in which the judgment was obtained, setting forth the facts referred to in subsection (3) of this section, and the court shall direct issuance of a special execution directed to the sheriff of Ada county of this state requiring the sheriff to sell the assets and securities of the insurer on deposit or so much thereof as may be necessary to satisfy the judgment. The court's order authorizing the special execution shall direct that a copy of the judgment, petition, and writ of execution shall be served upon the director within five (5) days thereafter. Upon receipt of such service the director shall forthwith notify the insurer of the levy and require the insurer within such period as may be specified in the notice, which period shall be not less than ten (10) nor more than thirty (30) days after the date of the notice, to have its president or other duly authorized representative to attend with the insurer's key and the director to the opening of the box in which the insurer's deposit is kept. Upon the box being so opened the director shall extract therefrom and deliver to the sheriff for sale on execution deposited assets or securities of

the insurer in amount, up to the full amount so on deposit, not less than as required for the satisfaction of the judgment. All proceedings for the enforcement of the writ of execution against the deposit shall conform as nearly as may be to the practice in ordinary cases except as in this subsection specially provided.

(5) If the insurer, after notice by the director as required under subsection (4) of this section, willfully fails to attend to the opening of the box in which its deposit is kept, or willfully fails to permit the director to extract therefrom assets or securities as in subsection (4) of this section provided, the director shall after hearing held thereon forthwith revoke the insurer's certificate of authority and institute proceedings for the rehabilitation or liquidation of the insurer under chapter 33[, title 41, Idaho Code] of this code. In any such proceedings the judgment with respect to which execution was issued and leading to the insurer's failure as herein referred to, shall have a first and prior right and claim as to the assets and securities of the insurer constituting its deposit as levied against, as of the date of service upon the director of the copy of the judgment, petition, and writ of execution as provided for in subsection (4) of this section.

History.

1961, ch. 330, § 179, p. 645; am. 1994, ch. 240, § 10, p. 751; am. 2004, ch. 90, § 7, p. 325.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of the first sentence in subsection (5) was added by the compiler to conform to the statutory citation style.

Section 13 of S.L. 1994, ch. 240 read: "Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993." Section 36 of S.L. 1993, ch. 194 provided, "For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry

such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-811. Deficiency of deposit. — (1) For the purpose of determining the sufficiency of its deposit in this state the assets and securities of the insurer on deposit shall be valued at current market value.

(2) If for any reason the current market value of such assets and securities falls below the amount of deposit required of the insurer under this code, the insurer shall promptly deposit other or additional assets or securities eligible for deposit and in amount sufficient to cure the deficiency. If the insurer has failed to cure the deficiency within thirty (30) days after receipt of notice thereof by registered or certified mail from the director, the director shall forthwith without further notice revoke the insurer's certificate of authority.

History.

1961, ch. 330, § 180, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-812. Duration and release of deposit. — (1) Every deposit made in this state by an insurer pursuant to this code shall be so held as long as there is outstanding any liability of the insurer as to which the deposit was required; or, if the deposit was required under the retaliatory provision, [section 41-340, Idaho Code](#), the deposit shall be held for so long as the basis of such retaliation exists.

(2) Except for good cause found by the director after a hearing thereon, any such deposit shall be released and returned:

(a) To the insurer upon extinguishment by reinsurance or otherwise of all liability of the insurer for the security of which the deposit is held. If by reinsurance, the assuming insurer shall be one authorized to transact such insurance in this state.

(b) To the insurer, during solvency, to the extent such deposit is in excess of the amount required.

(c) To a depositing foreign or alien insurer, during its solvency, which has made a similar deposit in another state and has filed with the director the certificate or evidence thereof, under the conditions provided for in [section 41-316\(2\)\(b\) or 41-316\(2\)\(c\), Idaho Code](#).

(d) To the resulting or surviving corporation or to such person as it may designate for the purpose, upon effectuation of a merger or consolidation of the depositing insurer, and upon the resulting or surviving corporation being or becoming authorized to transact insurance in this state.

(e) Upon order of a court of competent jurisdiction, to the receiver, conservator, rehabilitator, or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets pursuant to delinquency proceedings brought against the insurer under [chapter 33\[, title 41, Idaho Code\]](#) of this code.

(3) Notwithstanding the provisions of subsections (1) and (2) of this section, the director, in his discretion, may release a deposit made in this state by an insurer pursuant to this code if the insurance regulatory body in

the insurer's state has been appointed the liquidator of the insurer by a court in that state and either of the following applies:

- (a) The director has no information or belief that there are any outstanding claims against the insurer by policyholders or creditors of the insurer in Idaho; or
- (b) The director believes that any claims by Idaho policyholders or creditors will be adequately protected pursuant to the liquidation proceedings in the insurer's domestic state.

History.

1961, ch. 330, § 181, p. 645; am. 1995, ch. 289, § 4, p. 967.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of paragraph (2)(e) was added by the compiler to conform to the statutory citation style.

§ 41-813. Proofs for release of deposit to insurer — Director's responsibility. — (1) Before authorizing or permitting the release of any deposit or excess portion thereof to the insurer, as provided in [section 41-812, Idaho Code](#), the director shall require the insurer, the applicable insurance regulatory official in the insurer's domestic state, or other appropriate entity to file with him a written statement in such form and with such verification as he deems advisable setting forth the facts upon which it bases its entitlement to such release.

(2) If release of the deposit is claimed by the insurer upon the ground that all its liabilities, as to which the deposit was held, have been assumed by another insurer authorized to transact insurance in this state, the insurer shall file with the director a copy of the contract or agreement of such reinsurance duly attested under the oath of an officer of each of the insurers parties thereto.

(3) If release of the deposit is claimed by a domestic insurer upon the ground that all its liabilities, as to which the deposit was held, have been terminated other than by reinsurance, the director shall make an examination of the affairs of the insurer for determination of the actuality of such termination.

(4) Upon being satisfied by such statement and reinsurance contract, or examination of the insurer if required under subsection (3) above, and by such other examination if any, of the affairs of the insurer as he deems advisable to make, that the insurer is entitled to the release of its deposit or excess portion thereof as provided in [section 41-812, Idaho Code](#), the director shall release the deposit or excess portion thereof to the insurer or its authorized representative.

(5) If the director wilfully fails faithfully to keep, deposit, account for or surrender any such assets or securities deposited through him, in the manner as authorized or required under this chapter, he shall be liable therefor upon his official bond, and suit may be brought upon the bond by any person injured by such failure. The director shall not, however, have any liability as to any assets or securities of an insurer released by him in good faith pursuant to the authority vested in him under this chapter.

History.

1961, ch. 330, § 182, p. 645; am. 1995, ch. 289, § 5, p. 967.

STATUTORY NOTES**Compiler's Notes.**

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Chapter 9

INSURANCE ADMINISTRATORS

Sec.

41-901. Definitions.

41-902. Written agreement necessary.

41-903. Payment to administrator.

41-904. Maintenance of information.

41-905. Advertising — Approval.

41-906. Premium collection and payment of claims.

41-907. Delivery of materials to covered individuals.

41-908. Compensation to the administrator.

41-909. Notice to covered individuals — Disclosure of charges and fees.

41-910. Registration requirement.

41-911. Home state license.

41-912. Nonresident administrator license.

41-913. Expiration and renewal of administrator license.

41-914. Annual report.

41-915. Grounds for denial, suspension or revocation of license.

41-916. Reporting of actions.

41-917. Provisions not limiting.

§ 41-901. Definitions. — For the purposes of this chapter:

(1) “Administrator” or “third party administrator” or “TPA” means any person who directly or indirectly underwrites, collects charges or premiums from or adjusts or settles claims on residents of this state in connection with life, annuity or health insurance coverage offered or provided by an insurer, except any of the following:

(a) An employer, or a wholly owned direct or indirect subsidiary of an employer, on behalf of its employees or the employees of one (1) or more subsidiaries or affiliated corporations of such employer.

(b) A union on behalf of its members.

(c) An insurance company that is either authorized to transact insurance in this state or acting as an insurer with respect to a policy lawfully issued and delivered by such company in and pursuant to the laws of a state in which the insurer was authorized to transact an insurance business, or a hospital, medical, dental or optometric service corporation or a health care service organization, including their sales representatives, possessing a valid certificate of authority in this state when engaged in the performance of their duties.

(d) An insurance producer licensed to sell life, annuities or health coverage in this state whose activities are limited exclusively to the sale, solicitation and negotiation of insurance.

(e) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(f) A trust, its trustees, agents and employees acting pursuant to such trust established in conformity with [29 U.S.C. 186](#).

(g) A trust exempt from taxation under [section 501\(a\) of the Internal Revenue Code](#), its trustees and employees acting pursuant to such trust or a custodian and the custodian’s agents or employees acting pursuant to a custodian account that meets the requirements of [section 401\(f\) of the Internal Revenue Code](#).

(h) A credit union or a financial institution that is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent they collect and remit premiums to licensed insurance producers or to limited lines producers or authorized insurers in connection with loan payments.

(i) A credit card issuing company that advances for and collects premiums or charges from its credit cardholders who have authorized such collection.

(j) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life, annuity or health insurance coverage.

(k) A person licensed as a managing general agent in this state whose activities are limited exclusively to the scope of activities conveyed under such license.

(l) A person who is affiliated with an insurer and who acts solely as an administrator for the direct and assumed insurance business of an affiliated insurer. The insurer is responsible for the acts of the administrator and is responsible for providing all of the administrator's books and records to the insurance director upon a request from the insurance director. For purposes of this paragraph, "insurer" means a licensed insurance company, hospital or professional service corporation or a managed care organization.

(2) "Affiliate" or "affiliated" means an entity or person who directly or indirectly through one (1) or more intermediaries controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Control," including the terms "controlling," "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to

vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in [section 41-3809\(11\), Idaho Code](#), that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and an opportunity to be heard and making specific findings of fact to support the determination that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) “Director” means the director of the Idaho department of insurance.

(5) “GAAP” means United States “generally accepted accounting principles” consistently applied.

(6) “Home state” means the District of Columbia and any state or territory of the United States in which an administrator is incorporated or maintains its principal place of business. If neither the state in which the administrator is incorporated nor the state in which it maintains its principal place of business has adopted the provisions of this chapter, or a substantially similar law governing administrators, the administrator may declare another state in which it conducts business to be its “home state.”

(7) “Insurer” means a person undertaking to provide life, annuity or health coverage or self-funded coverage who is subject to regulation under title 41, Idaho Code.

(8) “NAIC” means the “national association of insurance commissioners.”

(9) “Nonresident administrator” means an administrator with a home state other than Idaho.

(10) “Underwrites” or “underwriting” means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer or self-funded plan, or the overall planning and coordinating of a benefits program.

(11) “Uniform application” means the current version of the NAIC uniform application for third party administrators.

History.

[I.C., § 41-901](#), as added by 2010, ch. 31, § 2, p. 51; am. 2013, ch. 266, § 8, p. 652.

STATUTORY NOTES

Prior Laws.

Former §§ 41-901 to 41-909, which comprised S.L. 1961, ch. 330, §§ 183 to 191, p. 645; S.L. 1965, ch. 216, §§ 1, 2, p. 498; S.L. 1969, ch. 214, §§ 29, 30, p. 625, were repealed by S.L. 1972, ch. 164, § 7.

Former §§ 41-916 to 41-918, Issuance, refusal of license — License contents — Limited licenses, which comprised S.L. 1961, ch. 330, §§ 198-200; am. 1969, ch. 214, §§ 33, 34, p. 625; am. 1970, ch. 169, § 1, p. 495 were repealed by S.L. 1972, ch. 164, § 7.

Former § 41-919, License blanks — Duplicates, which comprised S.L. 1961, ch. 330, § 201, was repealed by 1969, ch. 214, § 72.

Former §§ 41-920 to 41-925, Continuation and expiration of licenses — Termination of appointment — Temporary license — Special requirements as to solicitors, which comprised S.L. 1961, ch. 330, §§ 202-207, p. 645; S.L. 1970, ch. 169, § 2, p. 495 were repealed by S.L. 1972, ch. 164, § 7.

Former § 41-926, Insurance vending machines, which comprised S.L. 1961, ch. 330, § 208, p. 645; am. 1969, ch. 214, § 35, p. 625, was repealed by S.L. 1970, ch. 127, § 2. Subsequently this section was enacted by S.L. 1970, ch. 127, § 1, p. 301 and repealed by S.L. 1972, ch. 164, § 7.

Former §§ 41-927 to 41-937, Place of business — Display of license — Exchange of business — Sharing commissions — Reporting and accounting for premiums — Nonresident brokers — Suspension of license — Return of license, which comprised S.L. 1961, ch. 330, §§ 209-219, p. 645, were repealed by S.L. 1972, ch. 164, § 7.

Former chapter 9 of Title 41, which comprised the following sections, was repealed by S.L. 2010, ch. 30, § 1, effective retroactively to February 1, 2010.

41-901. Definition. [[I.C., § 41-901](#), as added by 1983, ch. 186, § 1, p. 501; am. 1991, ch. 293, § 2, p. 754.]

41-902. Written agreement — Maintenance of records. [[I.C., § 41-902](#), as added by 1983, ch. 186, § 1, p. 501; am. 1990, ch. 213, § 54, p. 480.]

41-903. Administrator as intermediary between insurer and insured — Right of action preserved. [I.C., § 41-903, as added by 1983, ch. 186, § 1, p. 501.]

41-904. Maintenance of records — Access. [I.C., § 41-904, as added by 1983, ch. 186, § 1, p. 501; am. 1990, ch. 213, § 55, p. 480.]

41-905. Advertising — Approval. [I.C., § 41-905, as added by 1983, ch. 186, § 1, p. 501.]

41-906. Inclusion of underwriting standards. [I.C., § 41-906, as added by 1983, ch. 186, § 1, p. 501.]

41-907. Charges, fees, or premiums collected held in fiduciary capacity — Establishment of account — Disbursements. [I.C., § 41-907, as added by 1983, ch. 186, § 1, p. 501.]

41-908. Payment of claims on behalf of insurer. [I.C., § 41-908, as added by 1983, ch. 186, § 1, p. 501.]

41-909. Delivery of written communications. [I.C., § 41-909, as added by 1983, ch. 186, § 1, p. 501.]

41-910. Adjustment or settlement of claims — Compensation. [I.C., § 41-910, as added by 1983, ch. 186, § 1, p. 501.]

41-911. Bonding of administrators — Purpose. [I.C., § 41-911, as added by 1983, ch. 186, § 1, p. 501; am. 1995, ch. 289, § 6, p. 967; am. 1996, ch. 107, § 1, p. 410.]

41-912. Notice — Statement of charge or premium for coverage. [I.C., § 41-912, as added by 1983, ch. 186, § 1, p. 501.]

41-913. Certificate of registration — Fees — Expiration — Renewal — Revocation. [I.C., § 41-913, as added by 1983, ch. 186, § 1, p. 501; am. 1986, ch. 41, § 1, p. 125; am. 2006, ch. 45, § 1, p. 134.]

41-914. Waiver of certification requirements. [I.C., § 41-914, as added by 1983, ch. 186, § 1, p. 501.]

41-915. Provisions not limiting. [I.C., § 41-915, as added by 1983, ch. 186, § 1, p. 501.]

Amendments.

The 2013 amendment, by ch. 266, updated the statutory reference in subsection (3) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Federal References.

Sections 501(a) and 401(f) of the internal revenue code, referred to in paragraph (1)(g), are compiled as [26 U.S.C.S. §§ 501\(a\)](#) and [401\(f\)](#).

Compiler's Notes.

For more on the national association of insurance commissioners, referred to in subsection (8), see <http://naic.org> . For more on NAIC regulations for third-party administrators, see <http://www.naic.org/store/free/GDL-1090.pdf>.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-902. Written agreement necessary. — (1) No administrator shall act as such without a written agreement between the administrator and the insurer, and the written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and for five (5) years thereafter. The agreement shall be consistent with the provisions of this chapter and shall contain all provisions required in this chapter, except insofar as those requirements do not apply to the functions performed by the administrator.

(2) The written agreement shall include a statement of duties that the administrator is expected to perform on behalf of the insurer and the lines, classes or types of insurance for which the administrator is to be authorized to administer. The agreement shall make provision with respect to underwriting or other standards pertaining to the business underwritten by the insurer.

(3) The insurer or administrator may, with written notice to the other party and the director, terminate the written agreement as provided in the agreement. The insurer may suspend the underwriting authority of the administrator during the pendency of any dispute regarding the termination of the written agreement. The insurer shall fulfill any lawful obligations with respect to policies affected by the written agreement regardless of any dispute between the insurer and the administrator.

History.

I.C., § 41-902, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-902 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-903. Payment to administrator. — If an insurer utilizes the services of an administrator, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured shall be deemed to have been received by the insurer and the payment of return premiums or claims forwarded by the insurer to the administrator shall not be deemed payment to the insured or claimant until the payments are received by the insured or claimant. Nothing in this chapter limits any right of the insurer against the administrator resulting from the failure of the administrator to make payments to the insurer, insured parties or claimants.

History.

I.C., § 41-903, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-903 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-904. Maintenance of information. — (1) Every administrator shall maintain and make available to the insurer complete books and records of all transactions performed on behalf of the insurer. The books and records shall be maintained in accordance with prudent standards of insurance recordkeeping and shall be maintained for a period of not less than five (5) years from the date of their creation.

(2) The director shall have access to books and records maintained by an administrator for the purposes of examination, audit and inspection.

(3) The insurer shall own the records generated by the administrator pertaining to the insurer; however, the administrator shall retain the right to continuing access to books and records to permit the administrator to fulfill all of its contractual obligations to insured parties, claimants and the insurer, and its obligations to maintain records available to the director.

(4) In the event the insurer and the administrator cancel their agreement, notwithstanding the provisions of subsection (1) of this section, the administrator may, by written agreement with the insurer, transfer all records to a new administrator rather than retain them for five (5) years. In such cases, the new administrator shall acknowledge, in writing, that it is responsible for retaining the records of the prior administrator as required in subsection (1) of this section.

History.

I.C., § 41-904, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-904 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-905. Advertising — Approval. — An administrator may use only advertising pertaining to the business underwritten by an insurer that has been approved in writing by the insurer in advance of its use. Prior to approving the use of advertising by an administrator, the insurer shall first file the advertising with the director along with a certification in a form prescribed by the director that the advertising complies with Idaho law. The director may disapprove the use of the advertising on any of the grounds set forth in [section 41-1813, Idaho Code](#).

History.

[I.C., § 41-905](#), as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-905 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-906. Premium collection and payment of claims. — (1) All insurance charges or premiums collected by an administrator on behalf of or for an insurer, and the return of premiums received from that insurer, shall be held by the administrator in a fiduciary capacity. The funds shall be immediately remitted to the person entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the administrator in a federally or state insured financial institution. The written agreement between the administrator and the insurer shall provide for the administrator to periodically render an accounting to the insurer detailing all transactions performed by the administrator pertaining to the business underwritten by the insurer.

(2) All such funds, including charges, fees or premiums, shall be used to establish the premium tax under [section 41-402, Idaho Code](#).

(3) If charges or premiums deposited in a fiduciary account have been collected on behalf of one (1) or more insurers, the administrator shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each insurer. The administrator shall keep copies of all the records and, upon request of an insurer, shall furnish the insurer with copies of such records pertaining to deposits and withdrawals associated with the insurer.

(4) The administrator shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Withdrawals from the account shall be made as provided in the written agreement between the administrator and the insurer. The written agreement shall address, but not be limited to, the following:

- (a) Remittance to an insurer entitled to remittance;
- (b) Deposit in an account maintained in the name of the insurer;
- (c) Transfer to and deposit in a claims-paying account with claims to be paid as provided for in subsection (5) of this section;
- (d) Payment to a group policyholder for remittance to the insurer entitled to such remittance;

- (e) Payment to the administrator of its commission, fees or charges; and
- (f) Remittance of return premiums to the person or persons entitled to such return premiums.

(5) All claims paid by the administrator from funds collected on behalf of or for an insurer shall be paid only on drafts or checks of and as authorized by the insurer.

History.

I.C., § 41-906, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-906 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-907. Delivery of materials to covered individuals. — Any policies, certificates, booklets, termination notices or other written communications delivered by the insurer to the administrator for delivery to insured parties or covered individuals shall be delivered by the administrator promptly after receipt of instructions from the insurer to deliver them.

History.

I.C., § 41-907, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-907 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-908. Compensation to the administrator. — (1) An administrator shall not enter into an agreement or understanding with an insurer in which the effect is to make the amount of the administrator's commissions, fees or charges contingent upon savings effected by the adjustment, settlement and payment of losses covered by the insurer's obligations. This provision shall not prohibit an administrator from receiving performance-based compensation for providing hospital or other auditing services.

(2) The provisions of this section shall not prevent the compensation of an administrator from being based on premiums or charges collected or the number of claims paid or processed.

History.

I.C., § 41-908, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-908 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-909. Notice to covered individuals — Disclosure of charges and fees. — (1) Where the services of an administrator are utilized, the administrator shall provide a written notice approved by the insurer to covered individuals advising them of the identity of and relationship among the administrator, the policyholder and the insurer.

(2) Where an administrator collects funds, the reason for collection of each item shall be identified to the insured party and each item shall be shown separately from any premium. Additional charges may not be made for services to the extent the services have been paid for by the insurer.

(3) The administrator shall disclose to the insurer all charges, fees and commissions received from all services in connection with the provision of administrative services for the insurer, including any fees or commissions paid by insurers providing reinsurance.

History.

I.C., § 41-909, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-909 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-910. Registration requirement. — A person who directly or indirectly underwrites, collects charges or premiums from or adjusts or settles claims on residents of this state in connection with life, annuity or health coverage provided by a self-funded plan not regulated under title 41, Idaho Code, shall register with the director biennially on a form prescribed by the director, verifying its status as herein described.

History.

I.C., § 41-910, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-910 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-911. Home state license. — (1) A person shall apply to be an administrator in its home state and shall receive a license from the regulatory authority of its home state prior to performing any function of an administrator in this state.

(2) A person applying to Idaho as the home state shall submit to the director an application in the form prescribed by the director that shall include or be accompanied by the following information and documents:

(a) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, certificate of existence from the Idaho secretary of state and other applicable documents and all amendments to such documents;

(b) The bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(c) NAIC biographical affidavits for the individuals who are directly or indirectly responsible for the conduct of affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company, any shareholders or members holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the applicant and any other person who directly or indirectly exercises control or influence over the affairs of the applicant;

(d) Audited annual financial statements or reports for the two (2) most recent fiscal years that demonstrate that the applicant has a positive net worth. If the applicant has been in existence for less than two (2) fiscal years, the uniform application shall include financial statements or reports, certified by at least two (2) officers, owners or directors of the applicant and prepared in accordance with GAAP, for any completed fiscal years and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited

annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

- (i) Amounts shown on the consolidated audited financial report shall be shown on the worksheet;
- (ii) Amounts for each entity shall be stated separately; and
- (iii) Explanations of consolidating and eliminating entries shall be included.

The applicant shall also include such other information as the director may require in order to review the current financial condition of the applicant;

(e) In lieu of submitting audited financial statements, and upon written application by an applicant and good cause shown, the director may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, which shall include notes, are:

- (i) Reports compiled or reviewed by a certified public accountant; or
- (ii) Internal financial reports prepared in accordance with GAAP, certified by at least two (2) officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the applicant must also secure and maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of ten percent (10%) of funds handled for the benefit of Idaho residents or twenty thousand dollars (\$20,000). Administrators of self-funded plans in Idaho are subject to the mandatory surety bond requirement found in subsection (8) of this section, regardless of whether they file audited or unaudited financial reports;

(f) A statement describing the business plan, including information on staffing levels and activities, proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for

providing a sufficient number of experienced and qualified personnel in the areas of claims processing, recordkeeping and underwriting;

(g) The license application fee as provided for by rule; and

(h) Such other pertinent information as may be required by the director.

(3) An administrator licensed or applying for licensure under the provisions of this section shall make available for inspection by the director, copies of all contracts with insurers or other persons utilizing the services of the administrator.

(4) An administrator licensed or applying for licensure under the provisions of this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the director.

(5) The director may refuse to issue a license if the director determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction, or if the director determines that any of the grounds set forth in [section 41-915, Idaho Code](#), exist with respect to the applicant.

(6) A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the director, for so long as the administrator continues in business in this state and remains in compliance with the provisions of this chapter and any applicable rules.

(7) An administrator licensed or applying for licensure under the provisions of this section shall immediately notify the director of any material change in its ownership, control or other fact or circumstance affecting its qualification for a license in this state.

(8) An administrator licensed or applying for a home state license that administers or will administer self-funded health plans subject to regulation under chapter 40 or 41, title 41, Idaho Code, shall maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty. The bond shall be in the greater of the following amounts:

- (a) One hundred thousand dollars (\$100,000); or
- (b) An amount equal to the greater of ten percent (10%) of the contributions collected by the administrator from self-funded plans subject to regulation under chapters 40 and 41, title 41, Idaho Code, or ten percent (10%) of the benefits paid by such self-funded plans administered during the preceding calendar year. If the administrator did not administer any self-funded plans subject to regulation under chapter 40 or 41, title 41, Idaho Code, during the preceding calendar year, the bond shall be in an amount equal to ten percent (10%) of the contributions projected to be received by the administrator from such self-funded plans during the next calendar year.

History.

I.C., § 41-911, as added by 2010, ch. 31, § 2, p. 51; am. 2012, ch. 156, § 1, p. 430.

STATUTORY NOTES

Cross References.

Secretary of state, § 67-901 et seq.

Prior Laws.

Former § 41-911 was repealed. See Prior Laws, § 41-901.

Amendments.

The 2012 amendment, by ch. 156, in paragraph (2)(d), substituted “demonstrate” for “prove” in the first sentence and “certified by at least two (2) officers, owners or directors” for “certified by an officer” in the second sentence; added paragraph (2)(e), redesignating former paragraphs (2)(e), (f), and (g) as present paragraphs (2)(f), (g), and (h); substituted “applicant” for “administrator” three times in subsection (5); and, in the introductory paragraph in subsection (8), inserted “in a form prescribed by the director” and substituted “any insurer or self-funded plan” for “the insurer or insurers.”

Compiler’s Notes.

For more on GAAP, referred to in this section, see <http://www.accounting.com/resources/gaap/>.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-912. Nonresident administrator license. — (1) Unless an administrator has obtained a home state license in this state, any administrator who performs administrator duties in this state shall obtain a nonresident administrator license in accordance with the provisions of this section by filing with the director the uniform application, accompanied by a letter of certification. In lieu of requiring an administrator to file a letter of certification with the uniform application, the director may verify the nonresident administrator's home state certificate of authority or license status through an electronic database maintained by the NAIC, its affiliates or subsidiaries.

(2) An administrator shall not be eligible for a nonresident administrator license under the provisions of this section if it does not hold a license in a home state that has adopted under the provisions of this chapter or a substantially similar law governing administrators.

(3) Except as provided in subsections (2) and (8) of this section, the director shall issue to the administrator a nonresident administrator license promptly upon receipt of a complete application.

(4) Each nonresident administrator shall file biennially, as a part of its application for renewal of its license, a statement that its home state administrator license remains in force and has not been revoked or suspended by its home state during the preceding years.

(5) At the time of filing the application for licensing required under the provisions of this section the nonresident administrator shall pay a license application fee as provided for by rule.

(6) An administrator licensed or applying for licensure under the provisions of this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the director.

(7) A nonresident administrator is not required to hold a nonresident administrator license in this state if the administrator is licensed in its home state and the administrator's duties in this state are limited to:

(a) The administration of a group policy or plan and no more than a total of twenty percent (20%) of covered persons, for all plans the administrator services, reside in this state; and

(b) The total number of covered persons residing in this state is less than one hundred (100).

(8) The director may refuse to issue a nonresident administrator license, or delay the issuance of a nonresident administrator license, if the director determines that, due to events or information obtained subsequent to the home state's licensure of the administrator, the nonresident administrator cannot satisfy the requirements of this chapter or that grounds exist for the home state's revocation or suspension of the administrator's home state certificate of authority or license.

History.

I.C., § 41-912, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-912 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-913. Expiration and renewal of administrator license. — (1) A license issued pursuant to this chapter shall expire on December 31 of the year following its issuance, but may be renewed for a period of two (2) years commencing January 1 upon filing a renewal form prescribed by the director accompanied by a fee as provided for by rule. The renewal form shall be filed on or before December 31. Any renewal form postmarked or submitted electronically after December 31 shall be accompanied by an additional late filing fee in the amount of double the unpaid renewal fee. Any renewal postmarked after January 31 must be submitted as a new application with supporting documents and accompanied by the full application fee as provided for by rule.

(2) The license shall be renewed by the director unless the director determines that the administrator is not competent, trustworthy or financially responsible, or has had an insurance license denied, revoked or suspended for cause by any state, or otherwise does not meet the qualifications for licensure as set forth in this chapter.

History.

I.C., § 41-913, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-913 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-914. Annual report. — (1) Each administrator licensed under the provisions of this chapter shall file an annual report for the preceding calendar year with the director on or before July 1 of each year, or within such extension of time as the director for good cause may grant. The annual report shall include:

(a) An audited financial statement attested to by an independent certified public accountant. An audited annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

- (i) Amounts shown on the consolidated audited financial report shall be shown on the worksheet;
- (ii) Amounts for each entity shall be stated separately; and
- (iii) Explanations of consolidating and eliminating entries shall be included.

(b) In lieu of submitting an audited financial statement, and upon written application by an administrator and good cause shown, the director may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, which shall include notes, are:

- (i) Reports compiled or reviewed by a certified public accountant; or
- (ii) Internal financial reports prepared in accordance with GAAP, certified by at least two (2) officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the administrator must secure and maintain a surety bond in a form prescribed by the director for the use and benefit of the director to be held in trust for the benefit and protection of covered persons and any insurer or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of ten percent (10%) of funds handled for the benefit of Idaho residents or twenty thousand dollars (\$20,000).

(2) The annual report shall be in the form and contain such matters as the director prescribes and shall be verified by at least two (2) officers, owners or directors of the administrator.

(3) The annual report shall include the complete names and addresses of all insurers and for self-funded plans, all employers and trusts, with which the administrator had agreements during the preceding fiscal year. The report shall also include the number of Idaho residents covered by each of the plans.

History.

I.C., § 41-914, as added by 2010, ch. 31, § 2, p. 51; am. 2012, ch. 156, § 2, p. 430.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 156, in subsection (1), divided the existing provisions of the introductory paragraph into the present introductory paragraph and paragraph (a), added the (a) designation, substituting “attested to” for “performed” and redesignating the subordinate paragraphs, and added paragraph (b); in subsection (2), added the designation and inserted “annual” and “owners or directors”; and redesignated former subsection (2) as subsection (3), inserting “and for self-funded plans, all employers and trusts” and adding the last sentence.

Prior Laws.

Former § 41-914 was repealed. See Prior Laws, § 41-901.

Compiler’s Notes.

For more on GAAP, referred to in this section, see <http://www.accounting.com/resources/gaap/>.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-915. Grounds for denial, suspension or revocation of license. —

(1) The license of an administrator shall be denied, suspended or revoked if the director finds that the administrator:

- (a) Is in an unsound financial condition;
- (b) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public; or
- (c) Has failed to pay any judgment rendered against it in this state within sixty (60) days after the judgment has become final.

(2) The director may deny, suspend or revoke the license of an administrator if the director finds that the administrator:

- (a) Has violated any lawful rule or order of the director or any provision of title 41, Idaho Code;
- (b) Has refused to be examined or to produce its accounts, records and files for examination, or if any individual responsible for the conduct of affairs of the administrator, including members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company, any shareholder or member holding directly or indirectly ten percent (10%) or more of the voting stock, voting securities or voting interest of the administrator and any other person who exercises control or influence over the affairs of the administrator, has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to an examination, when required by the director;
- (c) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the administrator to secure full payment or settlement of such claims;

(d) Fails, at any time, to meet any qualification for which issuance of the license could have been refused had the failure then existed and been known to the director;

(e) Or any of the individuals responsible for the conduct of its affairs, including members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company, any shareholder or member holding directly or indirectly ten percent (10%) or more of its voting stock, voting securities or voting interest and any other person who exercises control or influence over its affairs, has been convicted of, or has entered a plea of guilty or nolo contendere to any crime that is deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#), or that evidences dishonesty, a lack of integrity and financial responsibility, or an unfitness and inability to provide acceptable service to the consuming public without regard to whether adjudication was withheld; or

(f) Is under suspension or revocation in another state.

(3) The director may, in his discretion and without advance notice or hearing, immediately suspend the license of an administrator if the director finds that one (1) or more of the following circumstances exist:

(a) The administrator is insolvent or impaired;

(b) A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the administrator has been commenced in any state;

(c) The financial condition or business practices of the administrator otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state; or

(d) A final order suspending or revoking the administrator's license in its home state has been entered.

(4) If the director finds that one (1) or more grounds exist for the suspension or revocation of a license issued under the provisions of this chapter, the director may, in lieu of or in addition to suspension or

revocation, impose an administrative penalty upon the administrator pursuant to [section 41-117, Idaho Code](#).

History.

[I.C., § 41-915](#), as added by 2010, ch. 31, § 2, p. 51; am. 2020, ch. 175, § 7, p. 500.

STATUTORY NOTES

Prior Laws.

Former § 41-915 was repealed. See Prior Laws, § 41-901.

Amendments.

The 2020 amendment, by ch. 175, substituted “crime that is deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#), or that evidences” for “felony, or to a misdemeanor that evidences bad moral character” near the end of paragraph (2)(e).

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-916. Reporting of actions. — (1) An administrator shall report to the director any administrative action taken against the administrator in another jurisdiction or by another governmental agency within thirty (30) days of the final disposition of the matter. The report shall include a copy of the order, consent order or other relevant legal documents.

(2) Within thirty (30) days of the initial pretrial hearing date, an administrator shall report to the director any criminal prosecution of the administrator or an individual responsible for the conduct of its affairs taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

History.

I.C., § 41-916, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-916 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-917. Provisions not limiting. — The requirements of this chapter are not a waiver or limitation of provisions of this title or other laws of this state but are additional requirements.

History.

I.C., § 41-917, as added by 2010, ch. 31, § 2, p. 51.

STATUTORY NOTES

Prior Laws.

Former § 41-917 was repealed. See Prior Laws, § 41-901.

Effective Dates.

Section 3 of S.L. 2010, ch. 31 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

Chapter 10

PRODUCER LICENSING

Sec.

41-1001. Purpose and scope.

41-1002. Terms construed.

41-1003. Definitions.

41-1004. License required.

41-1005. Exceptions to licensing.

41-1006. Application for examination.

41-1007. Application for producer license.

41-1008. Producer license.

41-1009. Nonresident producer license.

41-1010. Nonresident producers — Service of process.

41-1011. Issuance — Refusal of license.

41-1012. Exemption from examination.

41-1013. Continuation — Expiration of licenses — Continuing education statement.

41-1014. Assumed names.

41-1015. Temporary licensing.

41-1016. Administrative penalty — Suspension, revocation, refusal of license.

41-1017. Commissions.

41-1018. Appointments.

41-1019. Notification to director of termination.

41-1020. Reciprocity.

41-1021. Reporting of actions.

41-1022. Insurers must accept business through licensed producers only.

41-1023. Countersignature of policies — Power of attorney.

41-1024. Reporting and accounting for premiums.

41-1025. Rules.

41-1026. Procedure following suspension, revocation, denial — Reinstatement.

41-1027. Return of license.

41-1028. Inactive status.

41-1029. Severability.

41-1030. Producer compensation.

41-1031 — 41-1035. Agents, brokers and consultants — License required as to a particular insurer — Compensation — Exceptions to license requirement — Purpose of license — License for “controlled business” prohibited — Qualifications — Agents or brokers — Qualifications — Consultants. [Repealed.]

41-1036. Records.

41-1037. Requirements for bail agents — Findings — Purpose.

41-1038. Definitions.

41-1039. License required.

41-1039A. Notice.

41-1040. Bond required.

41-1041. Records.

41-1042. Collections and charges permitted.

41-1043. Collateral.

41-1044. Early surrender of defendant to custody — Return of premium.

41-1045. Responsibility for actions of others.

41-1046 — 41-1059. License requirements — Exceptions — Qualifications — Application — Examination — Exemption — Contents —

Continuation — Expiration — Agents — Brokers. [Repealed.]

41-1060 — 41-1068. Sale of insurance by vending machines — Licensed agents and brokers — Payment and sharing commissions. [Repealed.]

41-1069. [Reserved.]

41-1070 — 41-1071. Consultant's bond — Consultant's place of business, records. [Repealed.]

41-1072. Consultants — Combined licensing. [Repealed.]

41-1073 — 41-1080. Consultants — Sharing commissions — Nonresident — Change of address — Administrative penalty — Suspension, revocation or refusal of license — Reinstatement. [Repealed.]

41-1081. Requirements for sale of portable electronics insurance — Findings — Purpose.

41-1082. Definitions.

41-1083. Licensure of vendors.

41-1084. Requirements for sale of portable electronics insurance.

41-1085. Authority of vendors of portable electronics.

41-1086. Responsibility for actions of others.

41-1087. Suspension or revocation of license.

41-1088. Termination of portable electronics insurance.

41-1089. Application for license and fees.

41-1090. Short title.

41-1091. Definitions.

41-1092. Requirements for limited lines travel insurance producers.

41-1093. Registration required.

41-1094. Type of policy.

41-1095. Responsibility of limited lines travel insurance producers.

41-1096. No negative option or opt out.

41-1097. Enforcement.

§ 41-1001. Purpose and scope. — (1) This chapter governs the qualifications and procedures for the licensing of insurance producers. It simplifies and organizes statutory language to improve efficiency, permits the use of new technology and reduces costs associated with issuing and renewing insurance licenses.

(2) This chapter applies to adjusters to the extent provided in [section 41-1108, Idaho Code](#), and to surplus lines brokers to the extent provided in sections 41-1223 and 41-1224, Idaho Code. Except where expressly made applicable, this chapter does not apply to title insurance under chapter 27, title 41, Idaho Code.

History.

[I.C., § 41-1001](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former §§ 41-1001 to 41-1029 and 41-1036, comprising S.L. 1961, ch. 330, §§ 220 to 236, p. 645; S.L. 1969, ch. 214, §§ 36, 37, p. 625 were repealed by S.L. 1972, ch. 164, § 7.

RESEARCH REFERENCES

ALR. — Duty and liability of insurance broker or agent to insured with respect to terms and coverage of insurance policies. [64 A.L.R.3d 398](#); [72 A.L.R.3d 704](#); [72 A.L.R.3d 735](#); [72 A.L.R.3d 747](#).

§ 41-1002. Terms construed. — Wherever the terms “agent” or “broker” appear in title 41, Idaho Code, or in the rules of the department, they shall be understood and construed to mean “producer” as defined in [section 41-1003\(8\), Idaho Code](#), except as used in [section 41-1018, Idaho Code](#), and any other sections where it is apparent from the language that the terms should not be so construed.

History.

[I.C., § 41-1002](#), as added by 2001, ch. 296, § 3, p. 1044; am. 2002, ch. 281, § 1, p. 823.

STATUTORY NOTES

Prior Laws.

Former § 41-1002 was repealed. See Prior Laws, § 41-1001.

§ 41-1003. Definitions. — (1) “Business entity” means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(2) “Home state” means the District of Columbia and any state or territory of the United States or any province of Canada in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

(3) “License” means a document issued by the director authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

(4) “Limited lines insurance” is insurance which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to [section 41-1008\(1\)\(a\) through \(g\), Idaho Code](#), and shall include, but not be limited to: credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (GAP) insurance, transportation baggage insurance, transportation ticket policies covering personal accident insurance, pet insurance, portable electronics insurance, travel insurance or any other line of insurance that the director deems necessary to recognize for the purposes of complying with [section 41-1009\(5\), Idaho Code](#).

(5) “Limited lines producer” means a producer authorized by the director to sell, solicit or negotiate limited lines insurance. “Limited lines producer” includes a “limited lines travel insurance producer” as used in [sections 41-1090 through 41-1096, Idaho Code](#).

(6) “Negotiate” means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in the act either sells insurance or obtains insurance from insurers for purchasers.

(7) “Person” means an individual or a business entity.

(8) “Producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

(9) “Resident” means a person whose home state is Idaho or any other particular state identified in conjunction with the use of the term.

(10) “Sell” means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(11) “Solicit” means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company or companies.

(12) “Terminate” means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer’s authority to transact insurance for or on behalf of an insurer.

(13) “Uniform application” means the current version of the national association of insurance commissioners (NAIC) uniform application for resident and nonresident producer licensing.

(14) “Uniform business entity application” means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

History.

I.C., § 41-1003, as added by 2001, ch. 296, § 3, p. 1044; am. 2012, ch. 226, § 1, p. 619; am. 2017, ch. 198, § 1, p. 494.

STATUTORY NOTES

Prior Laws.

Former § 41-1003 was repealed. See Prior Laws, § 41-1001.

Amendments.

The 2012 amendment, by ch. 226, inserted “portable electronic insurance” near the end of subsection (4).

The 2017 amendment, by ch. 198, inserted “travel insurance” near the end of subsection (4); and added the second sentence in subsection (5).

Compiler's Notes.

As to national association of insurance commissioners (NAIC), referred to in subsections (13) and (14), see *<http://naic.org>*.

The abbreviations enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1004. License required. — (1) A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed as a producer for that line of authority in accordance with this chapter.

(2) A person shall not, for a fee, engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages under any policy of insurance that could be issued in Idaho unless that person is:

- (a) A licensed insurance producer offering advice concerning a class of insurance as to which the producer is licensed to transact business in this state;
- (b) An attorney rendering services in the performance of the duties of an attorney;
- (c) A certified public accountant rendering services in the performance of the duties of a certified public accountant, as authorized by law;
- (d) An actuary rendering actuarial services if such actuary is a member of an organization determined by the director as establishing standards for the actuarial profession;
- (e) A person providing services to producers or authorized insurers only;
- (f) A person rendering services as an expert pursuant to the Idaho rules of evidence;
- (g) An investment adviser, investment adviser representative or federally [federal] covered investment adviser as defined in [section 30-14-102, Idaho Code](#); or
- (h) A person rendering such services pursuant to a license issued in accordance with sections 41-1081 through 41-1089[, Idaho Code,} of this chapter.

History.

[I.C., § 41-1004](#), as added by 2001, ch. 296, § 3, p. 1044; am. 2002, ch. 282, § 1, p. 825; am. 2004, ch. 45, § 6, p. 169; am. 2012, ch. 226, § 2, p.

STATUTORY NOTES

Prior Laws.

Former § 41-1004 was repealed. See Prior Laws, § 41-1001.

Amendments.

The 2012 amendment, by ch. 226, inserted paragraph (2)(h) and made stylistic changes.

Compiler's Notes.

The bracketed insertion in paragraph (2)(g) was added by the compiler to reflect the terminology found in § 30-14-102.

The bracketed insertion in paragraph (2)(h) was added by the compiler to conform to the statutory citation style.

Effective Dates.

Section 8 of S.L. 2004, ch. 45 provided that the act should take effect on and after September 1, 2004.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

CASE NOTES

Decisions Under Prior Law

Independent agent.

Liability for negligence.

Purpose.

Sanctions.

Independent Agent.

Where the insurance agent was never held out to the public as an independent agent, his termination at will, upon presumably adequate notice as provided in the contract, did not violate a public policy. *Anderson v.*

[Farm Bureau Mut. Ins. Co., 112 Idaho 461, 732 P.2d 699 \(Ct. App. 1987\)](#) (decided under former § 41-1023).

This section does not bar an insurance company from imposing restrictions on competitive sales activities by its agents; it simply states that if such restrictions are imposed, the agent is not an “independent insurance agent” and cannot be represented as such to the public. [Anderson v. Farm Bureau Mut. Ins. Co., 112 Idaho 461, 732 P.2d 699 \(Ct. App. 1987\)](#) (decided under former § 41-1023).

Liability for Negligence.

Where insured had requested sufficient insurance to cover the total value of inventory of insured’s retail store, and where the insurance agency knew or should have known the amount of insurance necessary to effect complete coverage, the insurance agency was held liable in tort for its negligence in underinsuring insured’s inventory which was destroyed by fire. [McAlvain v. General Ins. Co. of Am., 97 Idaho 777, 554 P.2d 955 \(1976\)](#) (decided under former § 41-1030).

Purpose.

This section protects the public, not insurance agents. [Anderson v. Farm Bureau Mut. Ins. Co., 112 Idaho 461, 732 P.2d 699 \(Ct. App. 1987\)](#) (decided under former § 41-1023).

Sanctions.

The director of the department of insurance determined that (1) through its agents, insurance company had solicited insurance in Idaho, in violation of this section; (2) by its acceptance of customer’s application and its issuance of an insurance policy to her, insurance company had transacted insurance in Idaho without a certificate of authority, in violation of § 41-305(1); and (3) insurance company had paid a sales commission to agents who were not authorized to make that sale of insurance, in violation of § 41-1063(1) (now repealed); pursuant to the authority granted in § 41-327, the director assessed an administrative penalty against insurance company in the amount of \$1,000 which penalty was found to be reasonable. [Pan Am. Assurance Co. v. Department of Ins., 121 Idaho 884, 828 P.2d 913 \(Ct. App. 1992\)](#) (decided under former § 41-1030).

Where insurance company was found to have committed acts specifically defined as acts for which an insurer is held strictly accountable, although the violation of this section and §§ 41-305 and 41-1063 (now repealed) arguably resulted from the agents' submission of a false application, insurance company nonetheless was responsible under these sections and was subject to sanctions by the director of the department of insurance. *Pan Am. Assurance Co. v. Department of Ins.*, 121 Idaho 884, 828 P.2d 913 (Ct. App. 1992) (decided under former § 41-1030).

RESEARCH REFERENCES

ALR. — Right of an insurance agent to commissions on renewal premiums. 36 A.L.R.3d 958.

§ 41-1005. Exceptions to licensing. — (1) Nothing in this chapter shall be construed to require an insurer to obtain an insurance producer license. In this section, the term “insurer” does not include an insurer’s officers, directors, employees, subsidiaries or affiliates.

(2) A license as an insurance producer shall not be required of the following:

(a) An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:

(i) The activities of the officer, director or employee are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance; or

(ii) The function of the officer, director or employee relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(iii) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person’s activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(b) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance, or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans, or performs administrative services relating to mass-marketed property and casualty insurance, and who does not receive a commission;

(c) An employer or association or its officers, directors, employees or the trustees of an employee trust plan, to the extent that the employer, association, officer, employee, director or trustee is engaged in the

administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which involves the use of insurance issued by an insurer, as long as the employer, association, officer, director, employee or trustee is not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(d) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers, and who are not individually engaged in the sale, solicitation or negotiation of insurance, and who do not receive a commission;

(e) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(f) A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one (1) state insured under that contract, provided that the person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;

(g) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission; or

(h) A person who, concurrent with the rental of a motor vehicle, provides contract options to the standard rental agreement which provides auto and travel related coverages through authorized insurers during a rental period not to exceed ninety (90) days.

History.

I.C., § 41-1005, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1005 was repealed. See Prior Laws, § 41-1001.

§ 41-1006. Application for examination. — (1) A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to section 41-1008(4) or 41-1012, Idaho Code. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and rules of this state. Examinations required by this section shall be developed and conducted under rules prescribed by the director of the department of insurance.

(2) Each individual applying for an examination shall remit a nonrefundable fee as promulgated by the director pursuant to [section 41-401, Idaho Code](#).

(3) An individual who fails to appear for the examination as scheduled or who fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

(4) Applications for licensure not received by the department within one hundred eighty (180) days of the successful completion of the examination shall be denied.

History.

[I.C., § 41-1006](#), as added by 2001, ch. 296, § 3, p. 1044; am. 2002, ch. 281, § 2, p. 823.

STATUTORY NOTES

Prior Laws.

Former § 41-1006 was repealed. See Prior Laws, § 41-1001.

§ 41-1007. Application for producer license. — (1) A person applying for a resident insurance producer license shall make application to the director on the uniform application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the applicant's knowledge and belief. Before approving the application, the director shall find that the applicant:

- (a) Is at least eighteen (18) years of age;
- (b) Has submitted the applicant's fingerprints as may be required by the director;
- (c) Has not committed any act that is a ground for denial, suspension or revocation of the license as set forth in title 41, Idaho Code;
- (d) Has paid the fees prescribed by the director pursuant to [section 41-401, Idaho Code](#); and
- (e) Has successfully passed the examinations for the lines of authority for which the applicant has applied.

(2) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the director shall find that:

- (a) The business entity has paid the fees prescribed by the director pursuant to [section 41-401, Idaho Code](#); and
- (b) The business entity has designated a licensed producer, who is an individual responsible for the business entity's compliance with the insurance laws and rules of this state.

(3) The director may require any documents which are reasonably necessary to verify the information contained in an application.

(4) Each insurer that sells, solicits or negotiates any form of limited line insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited lines insurance a program of instruction

that may be required to be approved by the director. If acceptable to the director, and as stated by rule, the program of instruction may be administered in place of the examination as required in [section 41-1006, Idaho Code](#). In addition, such course of instruction may be administered in place of any continuing education requirements pursuant to [section 41-1013, Idaho Code](#).

History.

[I.C., § 41-1007](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1007 was repealed. See Prior Laws, § 41-1001.

§ 41-1008. Producer license. — (1) Unless denied licensure pursuant to [section 41-1016, Idaho Code](#), persons who have met the requirements of sections 41-1006 and 41-1007, Idaho Code, shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one (1) or more of the following lines of authority:

- (a) Life insurance coverage on human lives, including benefits of endowment and annuities, benefits in the event of death or dismemberment by accident, and benefits for disability income;
- (b) Disability, including accident and health or sickness insurance coverage for sickness, bodily injury or accidental death and benefits for disability income;
- (c) Property insurance coverage for the direct or consequential loss or damage to property of every kind;
- (d) Casualty insurance coverage against legal liability, including liability for death, injury or disability or damage to real or personal property;
- (e) Variable life and variable annuity products, meaning insurance coverage provided under variable life insurance contracts and variable annuities;
- (f) Personal lines, meaning property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;
- (g) Any other line of insurance permitted under state laws or rules.

(2) An insurance producer license shall remain in effect unless revoked or suspended as long as the renewal fee promulgated by the director pursuant to [section 41-401, Idaho Code](#), is paid and the continuing education requirements for resident insurance producers are met in accordance with [section 41-1013, Idaho Code](#).

(3) An individual insurance producer who allows his or her license to lapse may, within twelve (12) months from the due date of the renewal fee, reinstate the same license without passing a written examination unless the licensee would otherwise be required to retest under [section 41-1013\(7\), Idaho Code](#). However, a penalty in the amount of double the unpaid

renewal fee shall be required for any renewal fee received after the due date.

(4) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, such as a long-term medical disability, may request that the director waive those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(5) The license shall contain the licensee's name, address, personal identification number, the date of issuance, the lines of authority, the expiration date and any other information the director deems necessary.

(6) Licensees shall inform the director by any means acceptable to the director of a change of address within thirty (30) days of the change. A business entity licensed as a producer shall inform the director by any means acceptable to the director of any change in ownership, officers, directors or the designated licensed producer responsible for compliance pursuant to [section 41-1007\(2\)\(b\), Idaho Code](#).

(7) In order to assist in the performance of the director's duties, the director may contract with nongovernmental entities, including the national association of insurance commissioners or its affiliates or subsidiaries, to perform any ministerial functions related to producer licensing, including the collection of fees, that the director and the nongovernmental entity may deem appropriate.

History.

[I.C., § 41-1008](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1008 was repealed. See Prior Laws, § 41-1001.

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (7), see <http://naic.org>.

§ 41-1009. Nonresident producer license. — (1) Unless denied licensure pursuant to [section 41-1016, Idaho Code](#), a nonresident applicant shall receive a nonresident producer license if:

- (a) The applicant is currently licensed as a resident and in good standing in his or her home state;
- (b) The applicant has submitted the proper request for licensure and has paid the fees set forth by rule pursuant to [section 41-401, Idaho Code](#);
- (c) The applicant has submitted or transmitted to the director the application for licensure that the applicant submitted to his or her home state or, in lieu of such application, a completed uniform application;
- (d) The applicant has submitted the applicant's fingerprints, if required by the director, on a form as prescribed by the director; and
- (e) The applicant's home state awards nonresident producer licenses to residents of this state on the same basis.

(2) The director may verify the producer's licensing status through the producer database maintained by the national association of insurance commissioners, its affiliates or subsidiaries, or by any other acceptable means.

(3) A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application shall be required for filing the change of address.

(4) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines broker in his or her home state shall receive a nonresident surplus lines broker license pursuant to subsection (1) of this section. Except as to subsection (1) of this section, nothing in this section otherwise amends or supersedes any provision of [section 41-1223, Idaho Code](#).

(5) Notwithstanding any other provision of this chapter, a person licensed as a limited lines producer in his or her home state shall receive a nonresident limited lines producer license, pursuant to subsection (1) of this

section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to [section 41-1008\(1\)\(a\) through \(g\)](#), Idaho Code.

History.

[I.C., § 41-1009](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1009 was repealed. See Prior Laws, § 41-1001.

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (2), see <http://naic.org>.

§ 41-1010. Nonresident producers — Service of process. — (1) Each person applying to be a nonresident producer shall, on a form prescribed by the director, appoint the director as his agent for purposes of receiving service of legal process issued against the producer in this state upon causes of action arising within this state out of transactions under the license. Service upon the director as an agent shall constitute effective legal service upon the producer.

(2) The appointment shall be irrevocable for as long as there could be any cause of action against the licensee arising out of his insurance transactions in or with respect to this state.

(3) Duplicate copies of such legal process against the licensee shall be served upon the director by a person competent to serve a summons. At the time of service the plaintiff shall pay the director an appropriate fee to be determined by rule and not exceeding thirty dollars (\$30.00).

(4) Upon receiving such service, the director shall send one (1) copy of the process by registered or certified mail with return receipt requested to the defendant licensee at his last address of record with the director.

(5) The director shall keep a record of the day and hour of such service upon him. No proceedings shall be brought against the producer, and the producer shall not be required to appear, plead or answer until the expiration of thirty (30) days after the date of service upon the director.

History.

I.C., § 41-1010, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1010 was repealed. See Prior Laws, § 41-1001.

§ 41-1011. Issuance — Refusal of license. — If after completion of application for a license, the taking and passing of any examination required under this chapter and, if required by the director, receipt of a report from the federal bureau of investigation based on the fingerprints of the applicant, the director finds that the applicant has fully met the requirements for a license, the director shall issue the license to the applicant; otherwise, the director shall refuse to issue the license and shall promptly notify the applicant and any appointing insurer or insurers of such refusal and state the grounds for the refusal. Pending the receipt of the report from the federal bureau of investigation, the director may, in his discretion, issue a temporary license if all other qualifications have been met.

History.

I.C., § 41-1011, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1011 was repealed. See Prior Laws, § 41-1001.

§ 41-1012. Exemption from examination. — (1) An individual who applies for an insurance producer license in this state and who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing examination if:

(a) The person is currently licensed in another state; or (b) The application is received within ninety (90) days of the cancellation of the applicant's previous license and the prior state issues a certification that: (i) At the time of cancellation, the applicant was in good standing in that state; or (ii) The state's producer database records, as maintained by the national association of insurance commissioners or its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the lines of authority requested.

(2) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to [section 41-1006, Idaho Code](#). No examination shall be required of that person to obtain any line of authority previously held in the prior state unless the director provides otherwise by rule.

History.

[I.C., § 41-1012](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1012 was repealed. See Prior Laws, § 41-1001.

Compiler's Notes.

As to national association of insurance commissioners, referred to in paragraph (1)(b)(ii), see <http://naic.org>.

§ 41-1013. Continuation — Expiration of licenses — Continuing education statement. — (1) All producer, adjuster, and surplus line broker licenses issued under this code shall continue in force until expired, suspended, revoked or otherwise terminated, subject to payment of the applicable continuation fee on or before the expiration date referred to in subsection (2) of this section, accompanied by a written request for such continuation and a continuing education statement verifying that the licensee has completed any continuing education requirements imposed by the director. An application for renewal is not complete unless it is submitted with both the applicable fee and the completed continuing education statement. Requests for continuation shall be made in writing on forms to be prescribed by the director.

(2) The director may fix the dates of expiration for licenses in such manner as is deemed by him to be advisable for an efficient distribution of the workload of his office. If the expiration date for a particular license or appointment would shorten the period for which the license or appointment continuation fee has been paid, no refund of an unearned fee shall be made. If the expiration date for a particular license or appointment would lengthen the period for which a license or appointment continuation fee has been paid, the director shall charge no additional fee for such lengthened period.

(3) Any license referred to in subsection (1) of this section for which no request for continuation, fee and completed continuing education statement are timely received by the director shall be deemed to have expired at midnight on the applicable expiration date.

(4) All sums tendered as fees for continuations of licenses as producer, limited lines producer, adjuster or surplus line broker shall be deemed earned when paid and shall not be subject to refund, except that the director shall refund any duplicate payment of fees.

(5) For the protection of the people of this state the director shall establish, by rule, additional educational requirements designed to maintain and improve the insurance skills and knowledge of resident producers after licensure by the department of insurance. The director shall also establish, by rule, an advisory committee comprised of representatives from each

segment of the insurance industry to assist the director in prescribing additional educational requirements. Such rules promulgated by the director shall include limits on the terms of service for members of the committee.

(6) Subject to subsection (3) of this section, the director shall not permit to be continued the license of any producer who is licensed pursuant to [section 41-1007, Idaho Code](#), who is a resident of this state, unless such person has demonstrated to the satisfaction of the director that in addition to meeting the standards contained in sections [section] 41-1007, (qualifications for producer license), Idaho Code, as may be applicable, all the additional educational requirements as the director may prescribe by rule have been met.

(7) Failure of the licensee to comply with any applicable additional education requirements prescribed by the director by rule by the expiration date of the license shall be grounds for the director to refuse to continue any such license. The licensee may reinstate his or her license by submitting proof of all education requirements within ninety (90) days from the date of expiration of the license and by submitting an additional administrative penalty of one hundred dollars (\$100) for a delinquency of one (1) day to thirty (30) days, two hundred dollars (\$200) for a delinquency of thirty-one (31) days to sixty (60) days, and three hundred dollars (\$300) for a delinquency of sixty-one (61) days to ninety (90) days. Following the ninetieth day from the date of nonrenewal of the license and up to one (1) year from the nonrenewal date, the licensee must complete all requirements for licensure including retesting, submission of a new application and payment of all new licensing fees. In addition, the individual must submit proof of completion of the required education requirements for the licensing period in which the license was terminated. After the license has been expired for one (1) year or more, the individual must reapply and retest as a new applicant.

History.

[I.C., § 41-1013](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1013 was repealed. See Prior Laws, § 41-1001.

Compiler's Notes.

The word “[section]” was inserted near the middle of subsection (6) to correct the language of the original enactment.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1014. Assumed names. — An insurance producer doing business under any name other than the producer's legal name is required to notify the director in writing prior to using the assumed name.

History.

I.C., § 41-1014, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1014 was repealed. See Prior Laws, § 41-1001.

§ 41-1015. Temporary licensing. — (1) The director may issue a temporary insurance producer license for a period not to exceed one hundred eighty (180) days without requiring an examination if the director deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

- (a) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled in order to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;
- (b) To a member or employee of a business entity licensed as an insurance producer upon the death or disability of an individual designated in the business entity application or the license;
- (c) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America; or
- (d) Pursuant to [section 41-1011, Idaho Code](#), or in any other circumstance where the director deems the public interest will best be served by the issuance of the temporary license.

(2) The director may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The director may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all actions of the temporary licensee, and may impose other similar requirements designed to protect insureds and the public. The director may by order revoke a temporary license, without the right to a prior hearing, if the interests of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

History.

[I.C., § 41-1015](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1015 was repealed. See Prior Laws, § 41-1001.

§ 41-1016. Administrative penalty — Suspension, revocation, refusal of license. — (1) The director may impose an administrative penalty not to exceed one thousand dollars (\$1,000), for deposit in the general fund of the state of Idaho, and may suspend for not more than twelve (12) months or may revoke or refuse to issue or continue any license issued under this chapter, chapter 27, title 41, Idaho Code (title insurance), chapter 11, title 41, Idaho Code (adjusters), or chapter 12, title 41, Idaho Code (surplus lines brokers), if the director finds that as to the licensee or applicant any one (1) or more of the following causes or violations exist:

- (a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;
- (b) Violating any provision of title 41, Idaho Code, department rule, subpoena or order of the director or of another state's insurance director;
- (c) Obtaining or attempting to obtain a license through misrepresentation or fraud;
- (d) Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance business;
- (e) Misrepresenting the terms of an actual or proposed insurance contract or application for insurance or misrepresenting any fact material to any insurance transaction or proposed transaction;
- (f) Being convicted of or pleading guilty to a crime that is deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#), or that evidences dishonesty, a lack of integrity and financial responsibility, or an unfitness and inability to provide acceptable service to the consuming public;
- (g) Admitting or being found to have committed any insurance unfair trade practice or fraud;
- (h) Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility, or being a source of injury and loss to the public or others, in the conduct of business in this state or elsewhere;

- (i) Having an insurance license denied, suspended or revoked in any other state, province, district or territory;
- (j) Forging another's name on an application for insurance or on any document related to an insurance transaction;
- (k) Improperly using notes or any other reference material to complete an examination for an insurance license;
- (l) Knowingly accepting insurance business from an individual who is not licensed;
- (m) Failing to comply with an administrative or court order imposing a child support obligation, provided however, that nothing in this provision shall be deemed to abrogate or modify chapter 14, title 7, Idaho Code;
- (n) Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax; or
- (o) In the case of a bail agent, compensating or agreeing to compensate any incarcerated person to influence or encourage another incarcerated person or other incarcerated persons to engage the bail agent's services or the services of the bail agent's company or of other bail agents employed by such bail company. For purposes of this subsection, compensating any incarcerated person shall include providing payment in any form to any person, organization or entity designated by the incarcerated person to receive such payment.

(2) The director shall, without hearing, suspend for not more than twelve (12) months, or shall revoke or refuse to continue any license issued under this chapter to a nonresident where:

- (a) The director has received a final order of suspension, revocation or refusal to continue from the insurance regulatory official or court of jurisdiction of the licensee's home state; or
- (b) A nonresident no longer has a license in the licensee's home state because the home state license was:
 - (i) Voluntarily surrendered for any reason except relicensing as a resident in another state; or

(ii) Otherwise nonrenewed by the nonresident and remains nonrenewed for a period greater than ninety (90) days beyond its expiration date, and without notice to the director of relicensing as a resident in another state.

If cause under this provision exists after the expiration of the twelve (12) months, successive suspensions may be imposed by the director without hearing.

(3) The license of a business entity may be suspended, revoked or refused if the director finds that the violation of an individual licensee, who is registered to or acting on behalf of the business entity, was known or should have been known by one (1) or more of the owners, officers or managers acting on behalf of the business entity and that the violation was not reported to the director and no corrective action was taken.

(4) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine or administrative penalty pursuant to subsection (1) of this section or any other applicable section.

(5) The director shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by title 41, Idaho Code, against any person who is under investigation for or charged with a violation of title 41, Idaho Code, or department rule, even if the person's license or registration has been surrendered or has lapsed by operation of law, or if the person has never been licensed.

History.

I.C., § 41-1016, as added by 2001, ch. 296, § 3, p. 1044; am. 2005, ch. 77, § 5, p. 258; am. 2006, ch. 49, § 3, p. 141; am. 2016, ch. 50, § 1, p. 144; am. 2017, ch. 258, § 1, p. 634; am. 2020, ch. 175, § 8, p. 500.

STATUTORY NOTES

Prior Laws.

Former § 41-1016 was repealed. See Prior Laws, § 41-1001.

Amendments.

The 2006 amendment, by ch. 49, substituted “or chapter 12, title 41, Idaho Code (surplus lines brokers), if the director finds” for “or any surplus lines broker license if, after not less than twenty-one (21) days’ notice of the opportunity for a hearing and of the charges against the licensee given as provided in [section 41-212\(3\), Idaho Code](#), to the licensee and to any appointing insurers represented (as to a producer who is appointed as an agent), the director finds” and inserted “or applicant” in the introductory paragraph in subsection (1); deleted former subsection (3) which read: “In the event that the director denies or refuses to renew an application for a license, the director shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant’s or licensee’s license. The applicant or licensee may make written demand upon the director within twenty-one (21) days for a hearing before the director to determine the reasonableness of the director’s action. The hearing shall be held pursuant to chapter 2, title 41, and chapter 52, title 67, Idaho Code”; redesignated former subsections (4) to (6) as (3) to (5); deleted “after hearing” following “director finds” in present subsection (3).

The 2016 amendment, by ch. 50, added the subsection (2)(a) designation and added subsection (2)(b).

The 2017 amendment, by ch. 258, in subsection (1), added paragraph (o).

The 2020 amendment, by ch. 175, substituted “ a crime that is deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#), or that evidences” for “any felony, or to a misdemeanor which evidences bad moral character” near the beginning of paragraph (1)(f).

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law

Effect of Bankruptcy Proceedings.

The exception under [11 U.S.C.S. § 362\(b\)\(4\)](#) to the automatic stay granted with regard to bankruptcy proceedings operated in favor of the department of insurance in a matter involving the suspension and

revocation of an insurance agent's license where the agent filed for bankruptcy prior to the suspension of his license and prior to the institution of proceedings to revoke same. Where the department of insurance contended that it was seeking the revocation of agent's insurance license based solely on his alleged fraudulent activities, the court was willing to accept the state's representations; however, if it were to appear that the purpose of the administrative proceedings were to collect premiums allegedly withheld by agent for his own use or to compensate the agent's victims, such activities would likely exceed the scope of the 11 U.S.C.S. § 362(b)(4) exception. *In re Fitch*, 123 Bankr. 61 (Bankr. D. Idaho 1991) (decided under former § 41-1077).

§ 41-1017. Commissions. — (1) An insurance company or insurance producer shall not pay a commission, service fee or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is not duly licensed as required under this chapter.

(2) A person shall not accept a commission, service fee or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is not duly licensed as required under this chapter.

(3) Renewals or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if that person was duly licensed as required under this chapter at the time of the sale, solicitation or negotiation.

(4) An insurer or insurance producer may pay or assign commissions, service fees or other valuable consideration to any person, regardless of whether that person is licensed as a producer, unless the payment or assignment would violate a specific section of title 41, Idaho Code, including, but not limited to, sections 41-1314 and 41-2708, Idaho Code, or department rule.

History.

I.C., § 41-1017, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1017 was repealed. See Prior Laws, § 41-1001.

CASE NOTES

Decisions Under Prior Law Sanctions.

The director of the department of insurance determined that (1) through its agents, insurance company had solicited insurance in Idaho, in violation of § 41-1030; (2) by its acceptance of customer's application and its issuance of an insurance policy to her, insurance company had transacted

insurance in Idaho without a certificate of authority, in violation of § 41-305(1); and (3) insurance company had paid a sales commission to agents who were not authorized to make that sale of insurance, in violation of this section; pursuant to the authority granted in § 41-327, the director assessed an administrative penalty against insurance company in the amount of \$1,000 which penalty was found to be reasonable. *Pan Am. Assurance Co. v. Department of Ins.*, 121 Idaho 884, 828 P.2d 913 (Ct. App. 1992) (decided under former § 41-1063).

Where insurance company was found to have committed acts specifically defined as acts for which an insurer is held strictly accountable, although the violation of §§ 41-305, 41-1030, and this section arguably resulted from the agents' submission of a false application, insurance company nonetheless was responsible under these sections and was subject to sanctions by the director of the department of insurance. *Pan Am. Assurance Co. v. Department of Ins.*, 121 Idaho 884, 828 P.2d 913 (Ct. App. 1992) (decided under former § 41-1063).

§ 41-1018. Appointments. — (1) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(2) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the director, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first insurance application is submitted.

(3) Upon receipt of the notice of appointment, the director shall verify, within a reasonable time not to exceed thirty (30) days, that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the director shall notify the insurer within five (5) days of his determination.

History.

I.C., § 41-1018, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1018 was repealed. See Prior Laws, § 41-1001.

CASE NOTES

Agency.

Because insurance company did not grant express authority to an independent insurance agency to issue insured endorsements and certificates of liability, there could have been no implied authority, given that implied authority is dependent on the existence of express authority. Likewise, because there was no direct relationship or any alleged direct communication between the agency and the insurance company, no apparent authority could have existed. *Nautilus Ins. Co. v. Pro-Set Erectors, Inc.*, 928 F. Supp. 2d 1208 (D. Idaho 2013).

§ 41-1019. Notification to director of termination. — (1) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the director within thirty (30) days following the effective date of the termination, using a format prescribed by the director, if the reason for termination is one of the reasons set forth in [section 41-1016, Idaho Code](#), or the insurer has knowledge that the producer was found by a court, governmental body or self-regulatory organization authorized by law to have engaged in any of the activities set forth in [section 41-1016, Idaho Code](#). Upon the written request of the director, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

(2) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer for any reason not set forth in [section 41-1016, Idaho Code](#), shall notify the director within thirty (30) days following the effective date of the termination, using a format prescribed by the director. Upon written request of the director, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

(3) The insurer or authorized representative of the insurer shall promptly notify the director in a format acceptable to the director if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the director in accordance with subsection (1) of this section.

(4) A copy of any notification shall be provided to the producer as follows:

(a) Within fifteen (15) days after making the notification required by subsections (1), (2) and (3) of this section, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any other reasons listed in [section 41-1016, Idaho Code](#), the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return

receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(b) Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the director. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the director's file and shall accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (6) of this section.

(5) Immunities.

(a) In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the director, or an organization of which the director is a member and that compiles information and makes it available to other insurance directors or regulatory or law enforcement agencies, shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees as a result of any statement or information required by or provided pursuant to this section or any information relating to any statement that may be requested in writing by the director from an insurer or producer or as a result of any statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under subsection (1) of this section was reported to the director, provided that the propriety of any termination for cause under subsection (1) of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(b) In any action brought against a person that may have immunity under paragraph (a) of this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the director, the party bringing the action shall plead specifically in any allegation that paragraph (a) of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

(c) Paragraph (a) or (b) of this subsection shall not abrogate or modify any existing statutory or common law privileges or immunities.

(6) Confidentiality.

(a) Any documents, materials or other information obtained by the director in an investigation pursuant to this section shall be exempt from public disclosure under chapter 1, title 74, Idaho Code.

(b) In order to assist in the performance of the director's duties under this chapter, the director:

(i) May share documents, materials or other information, including confidential and privileged documents and materials or information subject to paragraph (a) of this subsection, with other state, federal and international regulatory agencies and law enforcement authorities, and with the national association of insurance commissioners, its affiliates or subsidiaries, provided that the recipient agrees to maintain the confidentiality and privileged status of the documents, materials or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners, its affiliates or subsidiaries and from regulatory agencies and law enforcement authorities of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials or information received with notice or with the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials or information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(c) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in paragraph (b) of this subsection.

(d) Nothing in this chapter shall prohibit the director from releasing final adjudicated actions, including for cause terminations that are open to public inspection pursuant to chapter 1, title 74 and title 41, Idaho Code,

to a database or other clearinghouse service maintained by the national association of insurance commissioners or its affiliates or subsidiaries.

(7) Penalties for failing to report. An insurer, the authorized representative of the insurer, or a producer who fails to report as required under the provisions of this section or who is found by a court of competent jurisdiction to have reported with actual malice may, after notice and hearing, have his license or certificate of authority suspended or revoked and may be fined in accordance with section 41-1016 or 41-327, Idaho Code.

History.

I.C., § 41-1019, as added by 2001, ch. 296, § 3, p. 1044; am. 2015, ch. 141, § 109, p. 379.

STATUTORY NOTES

Prior Laws.

Former § 41-1019 was repealed. See Prior Laws, § 41-1001.

Amendments.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in paragraphs (6)(a) and (6)(d).

Compiler’s Notes.

As to national association of insurance commissioners, referred to in subsection (6), see *<http://naic.org>*.

§ 41-1020. Reciprocity. — (1) The director shall waive any requirements, except the requirements imposed by [section 41-1009, Idaho Code](#), for a nonresident producer license applicant with a valid license from his or her home state if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(2) A nonresident producer's satisfaction of his or her home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

History.

[I.C., § 41-1020](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1020, which comprised [I.C., § 41-1020](#), as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 2, p. 837, was repealed by S.L. 2001, ch. 296, § 2.

Cross References.

Continuing education requirements, § 41-1013.

Prior Laws.

Another former § 41-1020 was repealed. See Prior Laws, § 41-1001.

§ 41-1021. Reporting of actions. — (1) A producer shall report to the director any administrative action taken against the producer in another jurisdiction or by another governmental agency within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent order or other relevant legal documents.

(2) Within thirty (30) days of the initial pretrial hearing date, a producer shall report to the director any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

History.

I.C., § 41-1021, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1021, which comprised I.C., § 41-1021, as added by 1972, ch. 164, § 1, p. 376, was repealed by S.L. 2001, ch. 296, § 2.

Another former § 41-1021 was repealed. See Prior Laws, § 41-1001.

§ 41-1022. Insurers must accept business through licensed producers only. — (1) No authorized insurer shall make, write, place or cause to be made, written or placed in this state any policy, duplicate policy, or insurance contract of any kind, covering a subject of insurance resident, located or to be performed in this state through any person who is not then licensed as a producer under this chapter.

(2) The director may penalize, suspend or revoke the certificate of authority of any insurer violating this section in accordance with [section 41-327\(1\), Idaho Code](#).

History.

[I.C., § 41-1022](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1022, which comprised [I.C., § 41-1022](#), as added by 1972, ch. 164, § 1, p. 376, was repealed by S.L. 2001, ch. 296, § 2.

Compiler's Notes.

Another former § 41-1022 was repealed. See Prior Laws, § 41-1001.

§ 41-1023. Countersignature of policies — Power of attorney. — (1) When the signature or countersignature of a property or casualty producer is required on an insurance contract, or rider or endorsement thereto, the producer shall, except as provided in [section 41-337\(1\), Idaho Code](#), and subsection (2) of this section, affix his original written signature thereon.

(2) The property or casualty producer may grant a power of attorney in writing to an individual who is twenty-one (21) years of age or older, authorizing such person to countersign or cause a facsimile of the agent's signature to be placed on policies and endorsements in his name and on his behalf. The power of attorney shall be acknowledged by the agent under oath before a notary public and shall be kept on file in the agent's office.

History.

[I.C., § 41-1023](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1023, which comprised [I.C., § 41-1023](#), as added by 1972, ch. 164, § 1, p. 376; am. 1976, ch. 294, § 1, p. 1020; am. 1984, ch. 256, § 1, p. 612, was repealed by S.L. 2001, ch. 296, § 2.

Compiler's Notes.

Another former § 41-1023 was repealed. See Prior Laws, § 41-1001.

§ 41-1024. Reporting and accounting for premiums. — (1) All fiduciary funds received or collected by a producer shall be trust funds received by the producer in a fiduciary capacity, and the producer shall, in the applicable regular course of business, account for and pay the same to the person entitled to the funds. The producer shall establish a separate account for funds belonging to others in order to avoid a commingling of such fiduciary funds with his own funds. The producer may deposit and commingle in such separate account all fiduciary funds so long as the amount of such deposit so held for all other persons is reasonably ascertainable from the records and accounts of the producer. A producer who duly collects and deposits funds into a sweep account maintained by or for the benefit of an applicable insurer shall not be deemed to be in violation of the fiduciary fund account requirement. The director may promulgate rules relating to accounting for and handling of fiduciary funds and the fiduciary fund account.

(2) Fiduciary funds shall include all funds collected by an insurance producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or the producer's employer, and all funds collected by an insurance producer from an insurance company or its agents that are to be paid to a policyholder or claimant under any contract of insurance.

(3) Any producer who, not being lawfully entitled thereto, diverts or appropriates to his own use such trust or fiduciary funds or any portion thereof, whether or not such funds have been separately deposited, shall upon conviction be guilty of a felony.

History.

I.C., § 41-1024, as added by 2001, ch. 296, § 3, p. 1044; am. 2005, ch. 62, § 1, p. 220.

STATUTORY NOTES

Cross References.

Penalty for felony when not otherwise provided, § 18-112.

Prior Laws.

Former § 41-1024, which comprised I.C., § 41-1024, as added by 1972, ch. 164, § 1, p. 376, was repealed by S.L. 2001, ch. 296, § 2.

Compiler's Notes.

Another former § 41-1024 was repealed. See Prior Laws, § 41-1001.

CASE NOTES**Decisions Under Prior Law Premiums.**

This section does not distinguish between premium types; thus, there was sufficient evidence from which the hearing officer could conclude that insurance agent violated this section, whether the premiums withheld were characterized as “account current premiums” or “direct bill business.” *Knight v. Department of Ins.*, 124 Idaho 645, 862 P.2d 337 (Ct. App. 1993) (decided under former § 41-1064).

Suspending insurance agent's license, as contrasted with revoking it, reflected the hearing officer's observation that agent did not withhold premiums by stealth or deception; however, this did not change the fact that agent violated this section when he kept the premiums. *Knight v. Department of Ins.*, 124 Idaho 645, 862 P.2d 337 (Ct. App. 1993) (decided under former § 41-1064).

§ 41-1025. Rules. — The director may, in accordance with [section 41-211, Idaho Code](#), promulgate reasonable rules as are necessary or proper to carry out the purposes of this chapter.

History.

[I.C., § 41-1025](#), as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1025, which comprised [I.C., § 41-1025](#), as added by 1972, ch. 164, § 1, p. 376; am. 1972, ch. 395, § 1, p. 1139, was repealed by S.L. 2001, ch. 296, § 2.

Compiler's Notes.

Another former § 41-1025 was repealed. See Prior Laws, § 41-1001.

§ 41-1026. Procedure following suspension, revocation, denial — Reinstatement. — (1) Upon suspension, revocation, or refusal to continue any license, the director shall notify the licensee as provided in [section 41-212\(3\), Idaho Code](#), and, in the case of a producer who holds appointments from insurers, shall give like notice to the insurers represented.

(2) Suspension, revocation, or refusal of any one (1) license held by the licensee under title 41, Idaho Code, shall automatically suspend, revoke or refuse continuation of all other licenses held by the licensee under title 41, Idaho Code.

(3) The director shall not issue a license under title 41, Idaho Code, to or as to any person whose license has been revoked or continuance refused until after the expiration of not less than one (1) year, to a maximum of five (5) years, from the date of such revocation or refusal, which time period shall be set forth in the final order, or, if judicial review of such revocation or refusal is sought, not less than one (1) year, to a maximum of five (5) years, from the date of a final court order or decree affirming the revocation or refusal. If no time period is specified in the final order or final court order or decree, the time period shall be one (1) year. In the event the former licensee again files an application for a license under title 41, Idaho Code, the director may require the applicant to show good cause why the prior revocation or refusal to continue his license shall not be deemed a bar to the issuance of a new license.

(4) The director shall not issue a license under title 41, Idaho Code, to any person whose application for a license was previously denied until after the expiration of one (1) year from the date of such license denial or, if judicial review of such license denial is sought, one (1) year from the date of a final court order or decree affirming the license denial.

History.

[I.C., § 41-1026](#), as added by 2001, ch. 296, § 3, p. 1044; am. 2016, ch. 50, § 2, p. 144.

STATUTORY NOTES

Amendments.

The 2016 amendment, by ch. 50, in the section heading, inserted “denial” in subsection (3), rewrote the first sentence, which formerly read: “The director shall not issue a license under title 41, Idaho Code, to or as to any person whose license has been revoked or continuance refused until after the expiration of one (1) year from the date of such revocation or refusal or, if judicial review of such revocation or refusal is sought, within one (1) year from the date of a final court order or decree affirming the revocation or refusal” and inserted the second sentence; and added subsection (4).

Compiler’s Notes.

Former § 41-1026 was repealed. See Prior Laws, § 41-1001.

§ 41-1027. Return of license. — (1) All licenses, although issued and delivered as to the licensee producer, adjuster or surplus lines broker, shall at all times be the property of the state of Idaho. Upon any expiration, termination, suspension or revocation of the license, the licensee or other person having possession or custody of the license shall deliver it to the director either by personal delivery or by mail.

(2) In the case of any license that is lost, stolen or destroyed while in the possession of a licensee or other person, the director may, in lieu of the return of the license, accept the affidavits of the licensee or other person responsible for or involved in the safekeeping of such license concerning the facts of the loss, theft or destruction.

History.

I.C., § 41-1027, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Compiler's Notes.

Former § 41-1027 was repealed. See Prior Laws, § 41-1001.

§ 41-1028. Inactive status. — (1) Any individual producer who does not want to actively continue in the business of insurance may apply for inactive status of his license on forms prescribed by the director. The director, in his discretion, may grant or deny the application for inactive status and shall notify the licensee of this decision in writing. Inactive status of a license, once granted, shall apply to all licenses held by the licensee and shall continue in force until reactivated pursuant to this section or until the license is suspended or revoked pursuant to this chapter.

(2) During the period that a licensee remains on inactive status, the licensee may not transact the business of insurance in this state or engage in any other insurance activity which requires an active license. A licensee on inactive status may, subject to the terms of an insurer's contract with the licensee, continue to receive commissions or other compensation relative to business written by such licensee during active license status.

(3) Any individual producer whose license is placed on inactive status shall be exempt from compliance with continuing education requirements.

(4) An individual producer whose license is placed on inactive status shall be subject to payment of the applicable continuation fees.

(5) An individual producer whose license is on inactive status may apply for reactivation of a license on forms prescribed by the director. The request for reactivation shall include proof of completion of twenty (20) hours of continuing education earned during the twelve (12) months prior to reactivation or proof that the producer has retested and met the examination requirements as to any line or kind of insurance to be transacted under the reactivated license. The director, in his discretion, may grant or deny the application for reactivation.

History.

I.C., § 41-1028, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Cross References.

Continuing education requirements, § 41-1013.

Prior Laws.

Former § 41-1028, which comprised [I.C., § 41-1028](#), as added by 1972, ch. 164, § 1, p. 376, was repealed by S.L. 2001, ch. 296, § 2.

Compiler's Notes.

Another former § 41-1028 was repealed. See Prior Laws, § 41-1001.

§ 41-1029. Severability. — If any provision of this chapter or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

History.

I.C., § 41-1029, as added by 2001, ch. 296, § 3, p. 1044.

STATUTORY NOTES

Prior Laws.

Former § 41-1029, which comprised I.C., § 41-1029, as added by 1972, ch. 164, § 1, p. 376; am. 1995, ch. 289, § 7, p. 967, was repealed by S.L. 2001, ch. 296, § 2.

Compiler's Notes.

Another former § 41-1029 was repealed. See Prior Laws, § 41-1001.

§ 41-1030. Producer compensation. — (1) For purposes of this section:

(a) “Consumer” means an insured, a prospective insured or an employer group.

(b) “Retail producer” means a producer who solicits, negotiates with or sells an insurance contract directly to a consumer.

(c) “Wholesale producer” means a producer who solicits, negotiates or sells an insurance contract directly with a retail producer, but not with a consumer.

(2) Notwithstanding any other provision of title 41, Idaho Code, and as provided in this subsection, retail producers and wholesale producers may charge a fee or be compensated by a combination of fees and commissions.

(a) Before charging a fee to a consumer, a retail producer shall provide to the consumer a written statement that describes the services the retail producer will perform and the fees the retail producer will receive. Acceptance by the consumer of a fee arrangement shall be evidenced by the consumer signing and dating the fee statement.

(b) Before charging a fee to a retail producer, a wholesale producer shall provide to the retail producer a written statement that describes the services the wholesale producer will perform and the fees the wholesale producer will receive. Information regarding the amount of the fees charged by the wholesale producer shall be disclosed in writing on the face of the policy as a separately itemized charge.

History.

I.C., § 41-1030, as added by 2002, ch. 359, § 1, p. 1017.

STATUTORY NOTES

Prior Laws.

Former § 41-1030, which comprised I.C., § 41-1030, as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 4, p. 837 was repealed by S.L. 2001, ch. 296, § 2.

§ 41-1031 — 41-1035. Agents, brokers and consultants — License required as to a particular insurer — Compensation — Exceptions to license requirement — Purpose of license — License for “controlled business” prohibited — Qualifications — Agents or brokers — Qualifications — Consultants.[Repealed.]

STATUTORY NOTES

Compiler’s Notes.

The following sections were repealed by S.L. 2001, ch. 296, § 2: 41-1031 which comprised **I.C., § 41-1031**, as added by 1972, ch. 164, § 1, p. 376.

41-1032 which comprised **I.C., § 41-1032**, as added by 1972, ch. 164, § 1, p. 376; am. 1998, ch. 141, § 1, p. 504.

40-1033 which comprised **I.C., § 41-1033**, as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 5, p. 837.

41-1034 which comprised **I.C., § 41-1034**, as added by 1972, ch. 164, § 1, p. 376; am. 1976, ch. 118, § 1, p. 456; am. 1997, ch. 280, § 6, p. 837; am. 1999, ch. 97, § 1, p. 298.

41-1035 which comprised **I.C., § 41-1035**, as added by 1972, ch. 164, § 1, p. 376; am. 1976, ch. 161, § 1, p. 589; am. 1997, ch. 280, § 7, p. 837.

§ 41-1036. Records. — (1) A producer holding a license under this chapter shall make available through his principal place of business complete records of transactions placed through or countersigned by the producer.

(2) Records as provided in subsection (1) of this section shall include, but not be limited to: (a) The names and addresses of insurer and insured;

(b) The number and expiration date of the policy or contract; (c) The premium payable as to the policy or contract; (d) The date, time, insurer, insured and coverage of every binder made by the producer; (e) All disclosures made by a producer to an insured or to a prospective insured; and (f) Such other information as the director may reasonably require.

(3) The records shall be kept available for inspection by the director for at least five (5) years after the creation or the completion, whichever is later, of the respective transactions. The records may be maintained off-site and in electronic form if the records can be made available for inspection through the producer's principal place of business upon reasonable notice by the director.

History.

I.C., § 41-1036, as added by 2001, ch. 162, § 1, p. 571; am. 2002, ch. 281, § 4, p. 823; am. 2007, ch. 278, § 1, p. 809.

STATUTORY NOTES

Prior Laws.

Former § 41-1036, which comprised **I.C., § 41-1036**, as added by 1972, ch. 164, § 1, p. 376; am. 1977, ch. 250, § 1, p. 731; am. 1995, ch. 289, § 8, p. 967 was repealed by S.L. 2001, ch. 296, § 2.

Compiler's Notes.

Another former § 41-1036 was repealed. See Prior Laws, § 41-1001.

Amendments.

The 2007 amendment, by ch. 278, added the last sentence in subsection (3); and deleted subsection (4), which read: “This section shall not apply to life and disability insurance.”

§ 41-1037. Requirements for bail agents — Findings — Purpose. —

(1) Sections 41-1037 through 41-1045, Idaho Code, provide requirements for the regulation of bail agents in this state in addition to the requirements generally applicable to producers under this chapter.

(2) The legislature finds that:

(a) Bail agents provide an important local retail service to the retail consumers of bail bonds;

(b) Retail consumers of bail bonds and bail agents require a uniform and consistent regulatory framework that governs retail bail practices; and

(c) There is a need to provide consumer protection from unscrupulous and unfair practices.

(3) The purpose of this chapter is to provide that the department shall uniformly and exclusively license bail agents throughout the state of Idaho and that the department shall regulate such agents and bail transactions, provided the supreme court shall retain its inherent authority to regulate the transaction of bail with the court, including promulgating rules and uniform guidelines.

History.

I.C., § 41-1037, as added by 2003, ch. 104, § 1, p. 328; am. 2010, ch. 86, § 1, p. 165.

STATUTORY NOTES

Prior Laws.

Former § 41-1037, which comprised I.C., § 41-1037, as added by 1972, ch. 164, § 1, p. 376; am. 1995, ch. 289, § 9, p. 967; am. 1997, ch. 280, § 8, p. 837; am. 1999, ch. 97, § 2, p. 298, was repealed by S.L. 2001, ch. 296, § 2.

Amendments.

The 2010 amendment, by ch. 86, in the section heading, added “Findings — Purpose”; added the subsection (1) designation; and added subsections

(2) and (3).

§ 41-1038. Definitions. — As used in sections 41-1037 through 41-1045, Idaho Code:

(1) “Bail” means a monetary amount required by the court to release the defendant from custody and to ensure his appearance in court as ordered.

(2) “Bail agent” means a person who is a licensed producer in the line of surety insurance that is authorized by an insurer to execute or countersign undertakings of bail in connection with judicial proceedings.

(3) “Bail bond” means a financial guarantee, posted by a bail agent and underwritten by a surety insurance company, that the defendant will appear as ordered.

(4) “Collateral” means property of any kind given as security to obtain a bail bond.

(5) “Department” means the department of insurance.

(6) “Director” means the director of the department of insurance.

(7) “Person” means an individual or a business entity.

(8) “Retail consumers of bail bonds” means a defendant and any person who provides collateral to obtain any portion of a bail bond.

(9) “Surety” or “surety insurance company” means an admitted insurer authorized in the line of surety pursuant to title 41, Idaho Code.

History.

I.C., § 41-1038, as added by 2003, ch. 104, § 2, p. 328; am. 2010, ch. 86, § 2, p. 165.

STATUTORY NOTES

Prior Laws.

Former § 41-1038, which comprised **I.C., § 41-1038**, as added by 1972, ch. 164, § 1, p. 376; am. 1993, ch. 195, § 2, p. 531; am. 1997, ch. 280, § 9, p. 837; am. 1998, ch. 115, § 1, p. 430, was repealed by S.L. 2001, ch. 296, § 2.

Amendments.

The 2010 amendment, by ch. 86, added subsections (1), (3), and (7) through (9), and redesignated the existing subsections accordingly; and in present subsection (2), inserted “person who is.”

§ 41-1039. License required. — (1) No person shall hold himself out to be a bail agent or sell, solicit, negotiate, advise or consult regarding the terms of bail bond contracts in this state unless that person is licensed as a producer in the line of surety insurance. The director is vested with the exclusive authority to license bail agents and the authority to regulate the solicitation, negotiation and transaction of bail with retail consumers of bail bonds, provided however, that a court retains the authority to refuse to accept bail bonds from a surety or a bail agent pursuant to its inherent authority, pursuant to Idaho Code, or as provided by supreme court rules, guidelines or appellate decisions.

(2) A bail agent is authorized to execute and countersign undertakings of bail, including bail bonds, in connection with any judicial proceedings in each of the judicial districts of the state. Any sheriff or clerk of the district court shall accept bail bonds only from a bail agent, unless otherwise ordered by the court pursuant to subsection (1) of this section.

(3) In addition to the authority to revoke, suspend or refuse to issue a bail agent's license pursuant to [section 41-1016, Idaho Code](#), the director shall suspend a license for a period not to exceed six (6) months, after mailing notice to the last known address of the bail agent but prior to a hearing, if such bail agent:

(a) Has been convicted or has entered a guilty plea to any felony or to a misdemeanor evidencing theft, dishonesty, intimidation, threats, or violence; or

(b) Intentionally and fraudulently makes a false statement to a court in connection with a bail transaction.

(4) In addition to the provisions of subsection (3) of this section, the director may also suspend a license for a period not to exceed six (6) months, after mailing notice to the last known address of the bail agent but prior to a hearing, for reasons set forth in the rules of the department.

History.

[I.C., § 41-1039](#), as added by 2003, ch. 104, § 3, p. 328; am. 2010, ch. 86, § 3, p. 165; am. 2013, ch. 36, § 1, p. 77; am. 2019, ch. 266, § 3, p. 778.

STATUTORY NOTES

Prior Laws.

Former § 41-1039, which comprised I.C., § 41-1039, as added by 1972, ch. 164, § 1, p. 376, was repealed by S.L. 2001, ch. 296, § 2.

Amendments.

The 2010 amendment, by ch. 86, added the subsection (1) designation, and therein added the last sentence; and added subsections (2) through (5).

The 2013 amendment, by ch. 36, deleted former subsection (3), which read: “A bail agent’s license filed with the clerk of the district court is deemed proof that such bail agent is licensed pursuant to this chapter”; redesignated former subsections (4) and (5) as present subsections (3) and (4); and, in present subsection (4), substituted “subsection (3)” for “subsection (4)”.

The 2019 amendment, by ch. 266, rewrote paragraph (3)(a), which formerly read: “Has been convicted or has entered a guilty plea to any felony or to a misdemeanor which evidences bad moral character, dishonesty, a lack of integrity and financial responsibility, or an unfitness and inability to provide acceptable service to the consuming public; or”.

§ 41-1039A. Notice. — In the event that the director revokes or suspends a bail agent's license or a surety's certificate of authority, or lifts such revocation or suspension, the director shall immediately notify all judicial district trial court administrators and all sureties with whom the agent is appointed of the effective date of such revocation or suspension or of the lifting of such revocation or suspension.

History.

I.C., § 41-1039A, as added by 2010, ch. 86, § 4, p. 165.

§ 41-1040. Bond required. — After January 1, 2004, a producer shall not act as a bail agent unless the producer first files with the department and thereafter maintains in force a surety performance bond, executed by an authorized surety insurer, in favor of the director in the amount of fifteen thousand dollars (\$15,000). Such bond shall be held in trust for the benefit and protection of the public against a judicial or administrative determination by the department of loss by acts of fraud or dishonesty by the bail agent.

History.

I.C., § 41-1040, as added by 2003, ch. 104, § 4, p. 328; am. 2010, ch. 86, § 5, p. 165.

STATUTORY NOTES

Prior Laws.

Former § 41-1040, which comprised I.C., § 41-1040, as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 10, p. 837, was repealed by S.L. 2001, ch. 296, § 2.

Amendments.

The 2010 amendment, by ch. 86, inserted “by the department” in the last sentence.

§ 41-1041. Records. — (1) The bail agent shall provide copies of the bail contract, premium receipts, collateral receipts, and any related documents to the defendant and any cosigner at the time of the bail transaction.

(2) In addition to the records set forth in [section 41-1036, Idaho Code](#), a bail agent shall also maintain complete records pertaining to any collateral received and any charges collected for any bail bond transaction for at least five (5) years after the liability of the surety has been terminated.

History.

[I.C., § 41-1041](#), as added by 2003, ch. 104, § 5, p. 328.

STATUTORY NOTES

Prior Laws.

Former § 41-1041, which comprised [I.C., § 41-1041](#), as added by 1972, ch. 164, § 1, p. 376; am. 1990, ch. 168, § 1, p. 365; am. 1997, ch. 280, § 11, p. 837, was repealed by S.L. 2001, ch. 296, § 2.

§ 41-1042. Collections and charges permitted. — (1) Notwithstanding any other provision of this chapter, a bail agent in any bail transaction shall not, directly or indirectly, charge or collect money or other valuable consideration from any person except for the following:

(a) To pay premiums at the rates established by the insurer; (b) To provide collateral; (c) To reimburse the bail agent for actual expenses incurred in connection with the bail transaction, limited to the following: (i) Expenditures actually and reasonably incurred to verify underwriting information or to pay for notary public fees, recording fees, or necessary long distance telephone or telegram fees; provided however, that the total of all such expenditures reimbursed shall not exceed fifty dollars (\$50.00); and (ii) Travel expenses incurred more than twenty-five (25) miles from a bail agent's place of business, which includes any city or locality in which the bail agent advertises or engages in bail business, up to the amount allowed by the internal revenue service for business travel for the year in which the travel occurs.

(2) Except as permitted under this section, a bail agent shall not make any charge for his service in a bail transaction and the bail agent shall fully document all expenses for which the bail agent seeks reimbursement.

History.

I.C., § 41-1042, as added by 2003, ch. 104, § 6, p. 328.

STATUTORY NOTES

Prior Laws.

Former § 41-1042, which comprised I.C., § 41-1042, as added by 1972, ch. 164, § 1, p. 376; am. 1980, ch. 247, § 41, p. 582, was repealed by S.L. 2001, ch. 296, § 2.

CASE NOTES

Bond Contracts.

Plain text of this section permits a bail bond company to contemporaneously write a bail bond and contract with a client to indemnify the company for the cost of apprehending a defendant who jumps bail. Former [Idaho Admin. Code R. 18.01.04.016.02](#) [now repealed], which forbade such contracts, contravenes the statute and prejudiced the company's substantial right to contract freely, contrary to § 67-5279. [Two Jinn, Inc. v. Idaho Dep't of Ins.](#), 154 Idaho 1, 293 P.3d 150 (2013).

§ 41-1043. Collateral. — (1) A bail agent may accept collateral in connection with the bail bond transaction if the collateral is not excessive in relation to the face amount of the bond.

(2) All collateral received by a bail agent is received in a fiduciary capacity.

(a) Collateral received in the form of cash must be deposited and maintained in a trust account that is separate and apart from any other funds or assets of the bail agent.

(b) Collateral other than cash must be maintained in a separate and secure location apart from the assets of the bail agent.

(3) Collateral received must be returned to the person who deposited the collateral with the bail agent within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by collateral, is discharged.

(4) A copy of the order of the court wherein the bail or undertaking was ordered exonerated shall be deemed prima facie evidence of exoneration or termination of the liability.

(5) If a bail agent accepts collateral, the bail agent shall give a written receipt for the collateral to the person from whom the collateral was received. The receipt shall include a full and detailed accounting of the collateral received.

History.

I.C., § 41-1043, as added by 2003, ch. 104, § 7, p. 328.

STATUTORY NOTES

Prior Laws.

Former § 41-1043, which comprised **I.C., § 41-1043**, as added by 1972, ch. 164, § 1, p. 376; am. 1976, ch. 118, § 2, p. 456; am. 1997, ch. 280, § 12, p. 837, was repealed by S.L. 2001, ch. 296, § 2.

§ 41-1044. Early surrender of defendant to custody — Return of premium. — (1) A bail agent shall immediately return in full all premium and collateral associated with a bail transaction if the bail agent without good cause or in violation of the bail contract surrenders the defendant to custody before the time specified in the undertaking of bail or the bail bond for the appearance of the defendant or, if no time is specified in the undertaking or bond, before the time the defendant is lawfully required to appear in court.

(2) A bail agent has good cause for the early surrender of a defendant if the defendant has changed addresses without notifying the bail agent, engaged in self-concealment, left the jurisdiction of the court without permission of the bail agent or the court, materially breached the terms of the bail contract, or has otherwise acted in a manner that materially increases the risk of loss assumed by the bail agent or surety. A failure to pay the premium when due shall constitute good cause for early surrender only if at the time of the bail transaction the bail agent obtains the payor's signature on a written statement clearly stating the amount of premium due, the date by which the premium must be paid and that the failure to pay the premium by the due date will result in the early surrender of the defendant and forfeiture of any premium paid.

(3) Before surrendering a defendant early for good cause, a bail agent shall prepare a signed and dated written statement fully describing the facts upon which the agent relied in determining that good cause exists for the early surrender of the defendant. The statement shall be maintained as a record of the bail transaction and shall be made available to the department upon request. A bail agent who surrenders a defendant early for good cause shall not be entitled to seek recovery of any unpaid premium.

History.

I.C., § 41-1044, as added by 2003, ch. 104, § 8, p. 328.

STATUTORY NOTES

Prior Laws.

Former § 41-1044, which comprised I.C., § 41-1044, as added by 1972, ch. 164, § 1, p. 376; am. 1984, ch. 256, § 2, p. 612; am. 1997, ch. 280, § 13, p. 837, was repealed by S.L. 2001, ch. 296, § 2.

CASE NOTES

Cited *Garcia v. Absolute Bail Bonds, LLC*, 161 Idaho 616, 389 P.3d 161 (2016).

§ 41-1045. Responsibility for actions of others. — For purposes of licensing and regulation under title 41, Idaho Code, a bail agent is responsible for the actions of the bail agent's employees, contractors and agents acting on the bail agent's behalf in relation to bail transactions and matters arising out of bail transactions.

History.

I.C., § 41-1045, as added by 2003, ch. 104, § 9, p. 328.

STATUTORY NOTES

Prior Laws.

Former § 41-1045, which comprised I.C., § 41-1045, as added by 1972, ch. 164, § 1, p. 376; am. 1984, ch. 256, § 3, p. 612; am. 1993, ch. 195, § 1, p. 531, was repealed by S.L. 2001, ch. 296, § 2.

§ 41-1046 — 41-1059. License requirements — Exceptions — Qualifications — Application — Examination — Exemption — Contents — Continuation — Expiration — Agents — Brokers. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 2001, ch. 296, § 2:

41-1046 which comprised I.C., § 41-1046, as added by 1972, ch. 164, § 1, p. 376; am. 1980, ch. 167, § 1, p. 357; am. 1984, ch. 256, § 4, p. 612; am. 1987, ch. 121, § 1, p. 244; am. 1988, ch. 359, § 1, p. 1061; am. 1989, ch. 245, § 1, p. 593; am. 1993, ch. 195, § 3, p. 531; am. 1995, ch. 289, § 10, p. 967; am. 1997, ch. 280, § 14, p. 837.

41-1047 which comprised I.C., § 41-1047, as added by 1972, ch. 164, § 1, p. 376; am. 1980, ch. 167, § 2, p. 357; am. 1984, ch. 256, § 5, p. 612; am. 1995, ch. 289, § 11, p. 967.

41-1048 which comprised I.C., § 41-1048, as added by 1972, ch. 164, § 1, p. 376.

41-1049 which comprised I.C., § 41-1049, as added by 1972, ch. 164, § 1, p. 376; am. 1984, ch. 256, § 6, p. 612; am. 1990, ch. 213, § 56, p. 480; am. 1995, ch. 289, § 12, p. 967.

41-1050 which comprised I.C., § 41-1050, as added by 1972, ch. 164, § 1, p. 376.

41-1051 which comprised I.C., § 41-1051, as added by 1972, ch. 164, § 1, p. 376.

41-1052 which comprised I.C., § 41-1052, as added by 1972, ch. 164, § 1, p. 376; am. 1980, ch. 109, § 1, p. 247; am. 1997, ch. 280, § 15, p. 832.

41-1053 which comprised I.C., § 41-1053, as added by 1972, ch. 164, § 1, p. 376.

41-1054 which comprised I.C., § 41-1054, as added by 1972, ch. 164, § 1, p. 376.

41-1055 which comprised I.C., § 41-1055, as added by 1972, ch. 164, § 1, p. 376.

41-1056 which comprised I.C., § 41-1056, as added by 1972, ch. 164, § 1, p. 376.

41-1057 which comprised I.C., § 41-1057, as added by 1972, ch. 164, § 1, p. 376.

41-1058 which comprised I.C., § 41-1058, as added by 1972, ch. 164, § 1, p. 376; am. 1986, ch. 2, § 1, p. 40.

Former section 41-1059, which comprised I.C., § 41-1059, as added by 1972, ch. 164, § 1, p. 376 was repealed by S.L. 1997, ch. 280, § 16, effective July 1, 1997. And, former section 41-1059, as added by 2001, ch. 154, § 1, was repealed by S.L. 2001, ch. 296, § 2.

§ 41-1060 — 41-1068. Sale of insurance by vending machines — Licensed agents and brokers — Payment and sharing commissions. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 2001, ch. 296, § 2: 41-1060 which comprised I.C., § 41-1060, as added by 1972, ch. 164, § 1, p. 376; am. 1980, ch. 110, § 1, p. 248.

41-1061 which comprised I.C., § 41-1061, as added by 1972, ch. 164, § 1, p. 376.

41-1062 which comprised I.C., § 41-1062, as added by 1972, ch. 164, § 1, p. 376.

41-1063 which comprised I.C., § 41-1063, as added by 1972, ch. 164, § 1, p. 376.

41-1064 which comprised I.C., § 41-1064, as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 17, p. 837.

41-1065 which comprised I.C., § 41-1065, as added by 1972, ch. 164, § 1, p. 376.

41-1066 which comprised I.C., § 41-1066, as added by 1972, ch. 164, § 1, p. 376; am. 1999, ch. 97, § 3, p. 298.

41-1067 which comprised I.C., § 41-1067, as added by 1972, ch. 164, § 1, p. 376; am. 1999, ch. 97, § 4, p. 298.

41-1068 which comprised I.C., § 41-1068, as added by 1972, ch. 164, § 1, p. 376; am. 1999, ch. 97, § 5, p. 298.

Idaho Code § 41-1069

§ 41-1069. [Reserved.]

Idaho Code § 41-1070—41-1071

§ 41-1070 — 41-1071. Consultant's bond — Consultant's place of business, records. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 2001, ch. 296, § 2:

41-1070 which comprised I.C., § 41-1070, as added by 1972, ch. 164, § 1, p. 376.

41-1071 which comprised I.C., § 41-1071, as added by 1972, ch. 164, § 1, p. 376.

§ 41-1072. Consultants — Combined licensing. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised S.L. 1972, ch. 164, § 1, was repealed by S.L. 1976, ch. 161, § 2.

§ 41-1073 — 41-1080. Consultants — Sharing commissions — Nonresident — Change of address — Administrative penalty — Suspension, revocation or refusal of license — Reinstatement. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 2001, ch. 296, § 2: 41-1073 which comprised I.C., § 41-1073, as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 18, p. 837.

41-1074 which comprised I.C., § 41-1074, as added by 1972, ch. 164, § 1, p. 376.

41-1075 which comprised I.C., § 41-1075, as added by 1972, ch. 164, § 1, p. 376.

41-1076 which comprised I.C., § 41-1076, as added by 1972, ch. 164, § 1, p. 376.

41-1077 which comprised I.C., § 41-1077, as added by 1972, ch. 164, § 1, p. 376; am. 1975, ch. 246, § 2, p. 658; am. 1986, ch. 40, § 1, p. 124; am. 1987, ch. 121, § 2, p. 244; am. 1997, ch. 280, § 19, p. 837.

41-1078 which comprised I.C., § 41-1078, as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 20, p. 837.

41-1079 which comprised I.C., § 41-1079, as added by 1972, ch. 164, § 1, p. 376; am. 1997, ch. 280, § 21, p. 837.

41-1080 which comprised I.C., § 41-1080, as added by 1995, ch. 289, § 13, p. 967; am. 1997, ch. 280, § 22, p. 837.

§ 41-1081. Requirements for sale of portable electronics insurance — Findings — Purpose. — (1) Sections 41-1081 through 41-1089, Idaho Code, set forth requirements for the sale of portable electronics insurance in this state.

(2) The legislature finds that portable electronics insurers and insurance producers who sell, solicit or negotiate the offer or sale of such insurance in this state shall be supervised and regulated by the department of insurance in a uniform and consistent manner.

History.

I.C., § 41-1081, as added by 2012, ch. 226, § 3, p. 619.

STATUTORY NOTES

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1082. Definitions. — As used in sections 41-1081 through 41-1089, Idaho Code:

(1) “Customer” means a person who purchases portable electronics or services.

(2) “Enrolled Customer” means a customer who purchases coverage under a portable electronics insurance policy issued to a vendor of portable electronics, which vendor would be the insured under a master or group policy.

(3) “Location” means any physical location in the state of Idaho or any website, call center site or similar location directed to residents of the state of Idaho.

(4) “Portable electronics” means electronic devices that are portable in nature and includes accessories and any services related to the use of such device.

(5)(a) “Portable electronics insurance” means insurance providing coverage for the repair or replacement of portable electronics against any one (1) or more of the following causes of loss: loss of the portable electronic device, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss;

(b) “Portable electronics insurance” does not include:

(i) A service contract as defined in section 41-114A, Idaho Code;

(ii) A policy of insurance covering a seller’s or a manufacturer’s obligations under a warranty; or

(iii) A homeowner’s, renter’s, private passenger automobile, commercial multi-peril or similar insurance policy.

(6) “Portable electronics transaction” means:

(a) The sale or lease of portable electronics by a vendor to a customer; or

(b) The sale of a service related to the use of portable electronics by a vendor to a customer.

(7) “Supervising entity” means a business entity that is a licensed insurer or insurance producer that is authorized by an insurer to supervise the administration of a portable electronics insurance program.

(8) “Vendor” means a person in the business of engaging in portable electronics transactions directly or indirectly.

History.

I.C., § 41-1082, as added by 2012, ch. 226, § 4, p. 619.

STATUTORY NOTES

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1083. Licensure of vendors. — (1) A vendor is required to hold a limited lines license to sell or offer coverage under a policy of portable electronics insurance.

(2) A limited lines license issued pursuant to the provisions of this section shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(3) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the director to the supervising entity, the registry shall be open to inspection and examination by the director during regular business hours of the supervising entity.

(4) Notwithstanding any other provision of law, a limited lines license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

History.

I.C., § 41-1083, as added by 2012, ch. 226, § 5, p. 619.

STATUTORY NOTES

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1084. Requirements for sale of portable electronics insurance.

— (1) At every location where portable electronics insurance is offered or sold to customers, brochures or other written materials must be provided by the vendor to a prospective customer which:

(a) Disclose that portable electronics insurance may duplicate coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of insurance coverage;

(b) State that the purchase by the customer of a portable electronics insurance policy is not required in order to purchase or lease portable electronics or related services;

(c) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity and contact information of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the insurance coverage; and

(v) Key terms and conditions of the insurance coverage such as whether portable electronics may be repaired or replaced with similar make and model, reconditioned or nonoriginal manufacturer parts or equipment;

(d) Set forth the process for filing a claim, including a description of how to return portable electronics and any deadlines applicable thereto, any fees that may apply and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(e) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and that the person who paid the premium shall receive a pro rata refund or credit of any applicable unearned premium.

(2) The director may order a vendor to stop using any brochure or other written material that violates the requirements of this section or is otherwise found to be misleading or false.

(3) Portable electronics insurance may be offered on a month to month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(4) Eligibility and underwriting standards for customers electing to purchase portable electronics insurance coverage shall be established for each portable electronics insurance program by the insurer issuing a policy to a vendor.

History.

I.C., § 41-1084, as added by 2012, ch. 226, § 6, p. 619.

STATUTORY NOTES

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1085. Authority of vendors of portable electronics. — (1) Notwithstanding any other provision of law, the employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under the provisions of this chapter provided that:

(a) The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronics insurance pursuant to the provisions of this section;

(b) The insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity who shall supervise the administration of the program, to include development of a training program for employees and authorized representatives of the vendors concerning the applicable requirements of this chapter prior to the transaction of any personal electronics insurance. The training required by the provisions of this section shall comply with the following:

(i) The training shall be delivered to employees and authorized representatives of a vendor who are directly engaged in the activity of selling or offering portable electronics insurance;

(ii) The training may be provided in electronic form. However, if conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product being offered or sold that is conducted and overseen by employees of the supervising entity that are licensed pursuant to this chapter;

(iii) Each employee and authorized representative shall receive basic instruction concerning the portable electronics insurance offered to customers and the disclosures required pursuant to [section 41-1084, Idaho Code](#); and

(c) No employee or authorized representative of a vendor of portable electronics shall advertise, represent or otherwise hold himself out as a limited lines or other licensed insurance producer.

(2) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for portable electronics insurance coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included in the portable electronics or related services purchased. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in a nonsegregated account and is required to remit such amounts to the supervising entity within sixty (60) days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Failure to do so is a violation of this section. Vendors may receive compensation for billing and collection services.

History.

I.C., § 41-1085, as added by 2012, ch. 226, § 7, p. 619.

STATUTORY NOTES

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1086. Responsibility for actions of others. — For purposes of licensing and regulation under title 41, Idaho Code, a portable electronics limited lines licensee shall be responsible for the actions of the licensee's employees and authorized representatives acting on the licensee's behalf in relation to portable electronics insurance transactions and matters arising out of the same. Any violation of this chapter by the licensee's employees and authorized representatives acting on the licensee's behalf shall be considered a violation by the licensee.

History.

I.C., § 41-1086, as added by 2012, ch. 226, § 8, p. 619.

STATUTORY NOTES

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1087. Suspension or revocation of license. — If a vendor of portable electronics or its employee or authorized representative violates any applicable provision of this chapter including, but not limited to, [section 41-1016, Idaho Code](#), or applicable provisions of chapter 13, title 41, Idaho Code, or an applicable rule, the director may:

(1) Impose an administrative penalty pursuant to [section 41-117, Idaho Code](#). However, penalties arising from the same or similar conduct shall not exceed fifty thousand dollars (\$50,000) in the aggregate; and

(2) Impose other penalties that the director deems necessary and reasonable, including:

(a) Prohibiting such vendor from transacting portable electronics insurance pursuant to the provisions of this section at specific business locations where violations have occurred or from using specific employees or representatives in the transaction of portable electronics insurance; and

(b) Suspending, revoking or refusing to renew the license of such vendor.

History.

[I.C., § 41-1087](#), as added by 2012, ch. 226, § 9, p. 619.

STATUTORY NOTES

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1088. Termination of portable electronics insurance. —
Notwithstanding any other provision of law:

(1) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty (30) days' notice.

(2) If the insurer changes the terms and conditions, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure or other evidence indicating that a change in the terms and conditions has occurred and a summary of material changes. An enrolled customer shall be entitled to reject any change to the terms and conditions or cancel coverage, and the person who paid the premium shall receive a pro rata refund or credit of any applicable unearned premium within sixty (60) days of the receipt of notice from the customer that he wishes to cancel coverage.

(3) Notwithstanding subsection (1) of this section, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen (15) days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(4) Notwithstanding subsection (1) of this section, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(a) For nonpayment of premium;

(b) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(c) If an enrolled customer exhausts the aggregate limit of liability under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty (30) calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit

of liability until the insurer sends notice of termination to the enrolled customer and specifies the date of such termination.

(5) Where a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty (30) days prior to the termination, and any unearned premium shall be returned to the policyholder within sixty (60) days of such termination.

(6) An enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time, and the person paying the premium shall receive a pro rata refund or credit of any applicable unearned premium within sixty (60) days of the receipt of notice of cancellation from the customer.

(7) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to the provisions of this section or is otherwise required by law, it shall be in writing and sent within the required notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means if agreed to by the customer pursuant to [section 28-50-105, Idaho Code](#), and as set forth in this subsection. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to each affected enrolled customer's last known mailing address on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to each affected enrolled customer's last known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics at the time of purchase of the portable electronics insurance coverage. For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics shall be deemed consent to receive notices

and correspondence by electronic means at such address as long as notice of that consent is provided to the customer within thirty (30) days or less by mail or electronic means. The insurer or vendor of portable electronics shall maintain proof that the notice or correspondence was sent.

(8) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor by the supervising entity appointed by the insurer.

History.

I.C., § 41-1088, as added by 2012, ch. 226, § 10, p. 619; am. 2017, ch. 114, § 1, p. 265.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 114, in the next-to-last sentence in subsection (7), deleted “simultaneously” following “consent is” and added “within thirty (30) days or less by mail or electronic means”.

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1089. Application for license and fees. — (1) A sworn application for a limited lines license to sell, solicit or negotiate portable electronics insurance shall be completed and filed with the department of insurance on forms prescribed by the director to include such information as the director deems necessary.

(2) The application shall:

(a) Provide the name, residence address and other information required by the director for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this chapter, which designation shall satisfy the requirements of [section 41-1007\(2\)\(b\), Idaho Code](#). However, if the vendor derives more than fifty percent (50%) of its revenue from the sale of portable electronics insurance, the information noted in this subsection shall be provided for all officers, directors, and shareholders of record having beneficial ownership of ten percent (10%) or more of the vendor;

(b) Provide the location of the applicant's home office, both street address and mailing address, and phone number where such applicant may be reached during regular business hours; and

(c) Provide the syllabus for the training program that is developed by the supervising entity or the insurer that issued the portable electronics insurance policy to the vendor.

(3) Any vendor engaging in portable electronics insurance transactions on or before the effective date of [sections 41-1081 through 41-1089, Idaho Code](#), must apply for licensure within ninety (90) days of the application being made available to the vendor by the director. Any applicant commencing operations after the effective date of [sections 41-1081 through 41-1089, Idaho Code](#), must obtain a license prior to offering or selling portable electronics insurance.

(4) Notwithstanding any other provision of law, applicants for licensure pursuant to [sections 41-1081 through 41-1089, Idaho Code](#), whose home state does not issue a producer license with a similar line of authority as the license authorized by such sections shall be issued a portable electronics

limited lines license upon satisfying all applicable requirements of this chapter. However, any licensee whose home state does not authorize a limited lines license for portable electronics insurance in its home state after July 1, 2014, or such later date as may be determined by the director, shall obtain a property and casualty license under title 41, Idaho Code, or its license shall terminate in Idaho. For the purposes of this subsection, “home state” means the District of Columbia and any state or territory of the United States except Idaho, or any province of Canada, in which an applicant maintains such person’s principal place of residence or principal place of business.

(5) Initial licenses issued pursuant to [sections 41-1081 through 41-1089, Idaho Code](#), shall be valid for a period of twenty-four (24) months and expire thereafter unless renewed by the director upon completion of forms required by the director and payment of fees consistent with the provisions of this chapter.

(6) Each vendor of portable electronics licensed pursuant to this chapter shall pay to the director a fee of one thousand dollars (\$1,000) for an initial portable electronics limited lines license and five hundred dollars (\$500) for each renewal thereof. However, for a vendor engaged in portable electronics transactions at ten (10) or fewer locations in the state of Idaho, the fee shall not exceed one hundred dollars (\$100) for an initial license and for each renewal thereof.

History.

[I.C., § 41-1089](#), as added by 2012, ch. 226, § 11, p. 619.

STATUTORY NOTES

Compiler’s Notes.

The phrase “the effective date of sections 41-1081 through 41-1089” in subsection (3) refers to the effective date of those sections as enacted by S.L. 2012, Chapter 226, which was effective July 1, 2013.

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1090. Short title. — Sections 41-1090 through 41-1096, Idaho Code, shall be known and may be cited as the “Limited Lines Travel Insurance Act.”

History.

I.C., § 41-1090, as added by 2017, ch. 198, § 2, p. 494.

§ 41-1091. Definitions. — As used in this chapter:

(1) “Designated responsible producer” means the individual licensed producer responsible for ensuring compliance by the limited lines travel insurance producer with travel insurance laws and rules of the state, as set forth in [section 41-1092\(2\)\(c\), Idaho Code](#).

(2) “Limited lines travel insurance producer” means a person who is a limited lines producer as defined in [section 41-1003, Idaho Code](#).

(3) “Offer and disseminate” means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums and performing other activities permitted by the state.

(4) “Travel insurance” means insurance coverage for personal risks incident to planned travel including, but not limited to:

- (a) Interruption or cancellation of a trip or event;
- (b) Loss of baggage or personal effects;
- (c) Damages to accommodations or rental vehicles; and
- (d) Sickness, accident, disability or death occurring during travel.

“Travel insurance” does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting six (6) months or longer, including those working overseas as an expatriate or military personnel being deployed.

(5) “Travel retailer” means a business entity that makes, arranges or offers travel services and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

History.

[I.C., § 41-1091](#), as added by 2017, ch. 198, § 3, p. 494.

§ 41-1092. Requirements for limited lines travel insurance producers.

— Notwithstanding any other provision of law:

(1) The director may issue to an individual or business entity that has filed with the director an application, in a form and manner prescribed by the director, a limited lines travel insurance producer license that authorizes the limited lines travel insurance producer to sell, solicit or negotiate travel insurance on behalf of a licensed insurer.

(2) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer's business entity license only if the following conditions are met: (a) The limited lines travel insurance producer provides to policyholders of travel insurance:

(i) A description of the material terms or the actual material terms of the insurance coverage;

(ii) A description of the process for filing a claim;

(iii) A description of the review or cancellation process for the travel insurance policy, including any forfeiture fees; and (iv) The identity and contact information of the insurer and limited lines travel insurance producer.

(b) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the director of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register shall be maintained and updated annually, at a minimum, by the limited lines travel insurance producer and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations, as well as the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register from the previous year to the department on March 1 of each year. The limited lines travel insurance producer shall also certify that the registered travel retailer complies with [18 U.S.C. 1033](#). The limited lines travel insurance producer shall report its Idaho annual written premium to the director on an annual basis.

(c) The limited lines travel insurance producer has designated one (1) of its employees, who is a licensed individual producer, as a designated responsible producer who shall be responsible for the limited lines travel insurance producer's compliance with the travel insurance laws, rules and regulations of the state.

(d) The designated responsible producer, president, secretary, treasurer and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations shall comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer.

(e) The limited lines travel insurance producer has paid all applicable insurance producer licensing fees as set forth in applicable state law.

(f) The limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training that shall be subject to review by the director. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices and required disclosures to prospective customers.

(3) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that: (a) Provide the identity and contact information of the insurer and the limited lines travel insurance producer; (b) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and (c) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(4) A travel retailer's employees or authorized representatives who are not licensed as insurance producers may not: (a) Evaluate or interpret the technical terms, benefits and conditions of the offered travel insurance

coverage; (b) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(c) Hold himself or itself out as a licensed insurer, licensed producer or insurance expert.

History.

I.C., § 41-1092, as added by 2017, ch. 198, § 4, p. 494.

§ 41-1093. Registration required. — A travel retailer, whose insurance-related activities and those of its employees and authorized representatives are limited to offering and disseminating travel insurance, on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this chapter, is authorized to do so and receive related compensation upon registration by the limited lines travel insurance producer as described in [section 41-1092\(2\)\(b\), Idaho Code](#).

History.

[I.C., § 41-1093](#), as added by 2017, ch. 198, § 5, p. 494.

§ 41-1094. Type of policy. — Travel insurance may be provided under an individual policy or under a group or master policy.

History.

I.C., § 41-1094, as added by 2017, ch. 198, § 6, p. 494.

§ 41-1095. Responsibility of limited lines travel insurance producers.

— As the insurer designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with this chapter.

History.

I.C., § 41-1095, as added by 2017, ch. 198, § 7, p. 494.

§ 41-1096. No negative option or opt out. — No person offering travel insurance on an individual or group basis may do so using a negative option or option to opt out, that would require a consumer to take an affirmative action to deselect coverage such as unchecking a box on an electronic form when purchasing a trip. It shall not be an unfair trade practice to include blanket travel insurance coverage with the purchase of a trip, provided the coverage is not marketed as free.

History.

I.C., § 41-1096, as added by 2017, ch. 198, § 8, p. 494.

§ 41-1097. Enforcement. — The limited lines travel insurance producer and any travel retailer offering and disseminating travel insurance under the limited lines travel insurance producer license shall be subject to the provisions of [section 41-1016, Idaho Code](#), and other applicable provisions of this title. Violations of this act shall be considered an unfair trade practice under chapter 13, title 41, Idaho Code.

History.

[I.C., § 41-1097](#), as added by 2017, ch. 198, § 9, p. 494.

STATUTORY NOTES

Compiler's Notes.

The term “this act” near the beginning of the last sentence refers to S.L. 2017, chapter 198, which is codified as §§ 41-1003 and 41-1090 to 41-1097.

Chapter 11

ADJUSTERS

Sec.

41-1101. Scope of chapter.

41-1102. “Adjuster” defined.

41-1103. License required.

41-1104. Qualifications for adjuster’s license.

41-1105. Application for license.

41-1106. Scope of license.

41-1107. Emergency adjusters.

41-1108. Other provisions applicable.

§ 41-1101. Scope of chapter. — This chapter applies only as to adjusters, as defined in section 41-1102[, Idaho Code].

History.

1961, ch. 330, § 237, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion was added by the compiler to conform to the statutory citation style.

§ 41-1102. “Adjuster” defined. — (1) An “adjuster” is a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of such an independent contractor, or for fee or commission, investigates and negotiates settlement of claims arising under insurance contracts.

(2) None of the following is an “adjuster” for the purposes of this chapter: (a) A licensed attorney at law who is qualified to practice law in this state.

(b) The salaried employee of an authorized insurer, or group of such insurers under common control or ownership, or of a managing general agent, who adjusts losses for such insurer or insurers or for the authorized insurers represented by the general agent.

(c) The licensed agent of an authorized insurer who, at the insurer’s request, from time to time adjusts or assists in adjustment of losses arising under policies issued by such insurer.

(d) An individual who collects claim information from, or furnishes claim information to, claimants or those who are insured and who conducts data entry, including entering data into an automated claims adjudication system, provided that the individual is an employee of a licensed adjuster or its affiliate where no more than twenty-five (25) such persons are under the supervision of one (1) licensed adjuster or licensed agent. A licensed agent who acts as a supervisor or adjusts claims pursuant to the provisions of this paragraph is not required to also be licensed as an adjuster. For purposes of this section, “automated claims adjudication system” means a pre-programmed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims that: (i) May only be utilized by a licensed adjuster, licensed agent or supervised individuals operating pursuant to the provisions of this paragraph; (ii) Must comply with all claims payment requirements of the insurance code; and (iii) Must be certified as compliant with this section by a licensed adjuster who is an officer of a licensed business entity pursuant to the provisions of this chapter.

History.

1961, ch. 330, § 238, p. 645; am. 2012, ch. 226, § 12, p. 619.

STATUTORY NOTES**Amendments.**

The 2012 amendment, by ch. 226, added paragraph (2)(d).

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1103. License required. — No person shall in this state be, act as, or advertise or hold himself out to be, an adjuster unless then licensed as an adjuster under this chapter. No resident of Canada may be licensed as a resident adjuster or may designate Idaho as his home state, unless such person has successfully passed the adjuster examination and has complied with the other applicable provisions of this chapter. No resident of Canada may be licensed as a nonresident adjuster unless such person has obtained a resident or home state adjuster license in another state.

History.

1961, ch. 330, § 239, p. 645; am. 2012, ch. 226, § 13, p. 619.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 226, added the second and third sentences.

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1104. Qualifications for adjuster's license. — (1) Except as provided in subsection (2) of this section, the director shall not issue, continue, or permit to exist any license as an adjuster as to any person not qualified therefor as follows:

(a) Must be a natural person not less than twenty-one (21) years of age.

(b) Must be trustworthy, and be of good character and reputation as to morals, integrity, and financial responsibility, and must not have been convicted of any crime that is deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#).

(c) Must be a salaried employee of a licensed adjuster, or must have had experience or special education or training as to the investigation and settlement of loss of claims under insurance contracts of sufficient duration and extent reasonably to satisfy the director as to his competence to fulfill the responsibilities of an adjuster.

(d) If required by the director, must pass a written examination to test his knowledge of the duties and responsibilities of an adjuster and of matters involved in transactions under an adjuster's license. The examination shall be subject to the same applicable provisions as apply pursuant to title 41, Idaho Code, to examinations for license as insurance agent.

(2) A firm or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the license powers in this state is separately licensed, or is named in the firm or corporation license, and is qualified as for an individual license as adjuster under subsection (1) of this section. An additional full license fee shall be paid as to each individual in excess of one (1) so named in the firm or corporation license to exercise its powers.

History.

1961, ch. 330, § 240, p. 645; am. 1969, ch. 214, § 38, p. 625; am. 2012, ch. 226, § 14, p. 619; am. 2020, ch. 175, § 9, p. 500.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 226, substituted “pursuant to title 41, Idaho Code” for “under this code” in paragraph (1)(d) and made stylistic changes.

The 2020 amendment, by ch. 175, substituted “convicted of any crime that is deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#)” for “convicted of a felony or of any crime involving moral turpitude” at the end of paragraph (1)(b).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 15 of S.L. 2012, ch. 226 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

Effective Dates.

Section 16 of S.L. 2012, ch. 226 provided that the act should take effect on and after July 1, 2013.

§ 41-1105. Application for license. — The individual desiring to be licensed as an adjuster shall make written application therefor to the director, on forms as prescribed and furnished by the director. The application shall be accompanied by payment of the fee for the license as set forth by rule pursuant to [section 41-401, Idaho Code](#).

History.

1961, ch. 330, § 241, p. 645; am. 2001, ch. 85, § 4, p. 211.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1106. Scope of license. — Under his license an adjuster shall have authority to act as adjuster on behalf of the insurer only as to losses under insurance contracts.

History.

1961, ch. 330, § 242, p. 645.

§ 41-1107. Emergency adjusters. — No adjuster's license or qualifications shall be required as to any adjuster who is sent into this state by and on behalf of an authorized insurer or adjusting firm or corporation for the purpose of investigating or making adjustment of a particular loss under an insurance policy issued by an authorized insurer or as a lawful surplus line contract, or for the purpose of temporarily assisting or substituting for a licensed adjuster who is incapacitated due to illness, injury, or any unforeseeable or uncontrollable incident, or for the adjustment of a series of losses resulting from a catastrophe common to all such losses.

History.

1961, ch. 330, § 243, p. 645.

§ 41-1108. Other provisions applicable. — The following sections of chapter 10, title 41, Idaho Code, shall, to the extent so applicable, also apply as to adjuster licenses:

- (1) 41-1007(1), Idaho Code (application for producer license).
- (2) 41-1008, Idaho Code (producer license).
- (3) 41-1011, Idaho Code (issuance, refusal of license).
- (4) 41-1013, Idaho Code (continuation, expiration of license, continuing education statement).
- (5) 41-1016, Idaho Code (administrative penalty — suspension, revocation, refusal of license).
- (6) 41-1026, Idaho Code (procedure following suspension, revocation, denial — reinstatement).
- (7) 41-1027, Idaho Code (return of license).

History.

1961, ch. 330, § 244, p. 645; am. 1972, ch. 164, § 2, p. 376; am. 1999, ch. 97, § 6, p. 298; am. 2001, ch. 296, § 4, p. 1044; am. 2002, ch. 281, § 3, p. 823; am. 2016, ch. 50, § 3, p. 144.

STATUTORY NOTES

Amendments.

The 2016 amendment, by ch. 50, inserted “Idaho Code” in subsections (1) through (7) and inserted “denial” in subsection (6).

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 8 of S.L. 1972, ch. 164 provided the act should take effect from and after January 1, 1973.

Chapter 12

UNAUTHORIZED INSURERS AND SURPLUS LINES

Sec.

- 41-1201. Representing or aiding unauthorized insurer prohibited.
- 41-1202. Representing or aiding unauthorized insurer prohibited — Penalty.
- 41-1203. Suits by unauthorized insurer prohibited.
- 41-1204. Unauthorized insurers process act — Title — Interpretation.
- 41-1205. Purpose of process act.
- 41-1206. Acts constituting director as process agent.
- 41-1207. How process is served — Default judgment.
- 41-1208. Defense of action by unauthorized insurer.
- 41-1209. Unauthorized insurer failing to pay claim — Attorney fees.
- 41-1210. Exemptions from process act.
- 41-1211. Surplus line law — Short title — Purpose.
- 41-1212. Exemptions from surplus line law.
- 41-1213. Definitions.
- 41-1214. Conditions for export.
- 41-1215. Broker's affidavit.
- 41-1216. Open lines for export.
- 41-1217. Eligible surplus lines insurers.
- 41-1218. Eligible surplus line insurers — Penalty for violation.
- 41-1219. Evidence of the insurance — Changes — Penalty.
- 41-1220. Endorsement of contract.
- 41-1221. Surplus line insurance valid.
- 41-1222. Liability of insurer as to losses and unearned premiums.

- 41-1223. Licensing of surplus line brokers.
- 41-1224. Suspension or revocation of broker's license.
- 41-1225. Broker's bond. [Repealed.]
- 41-1226. Acceptance of business from agents.
- 41-1227. Records of broker.
- 41-1228. Annual report of broker.
- 41-1229. Tax on surplus lines.
- 41-1230. Failure to file report or remit tax — Penalty.
- 41-1231. Legal process against surplus line insurer.
- 41-1232. Rules and regulations.
- 41-1233. Report and tax of independently procured coverages.
- 41-1234. Records of insureds.
- 41-1235. False advertising act.
- 41-1236. Misrepresentation by unauthorized insurer.
- 41-1237. Misrepresentation — Action and penalties.

§ 41-1201. Representing or aiding unauthorized insurer prohibited.

— (1) No person shall in this state directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, any insurer not then authorized to transact such insurance in this state, in the solicitation, negotiation, procurement or effectuation of insurance or annuity contracts, or renewal thereof, or forwarding of applications for insurance, or in the dissemination of information as to coverage or rates, or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist such an insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state.

(2) This section does not apply to: (a) Matters authorized to be done by the director under the unauthorized insurers process act, sections 41-1204 through 41-1210[, Idaho Code].

(b) Surplus line insurance when written pursuant to the surplus line law, sections 41-1211 through 41-1232[, Idaho Code], and coverages specified in section 41-1212[, Idaho Code] (exemptions from surplus line law).

(c) Any transaction with respect to which the insurer is not required to have a certificate of authority pursuant to section 41-306[, Idaho Code,] (exceptions to certificate of authority requirement).

(d) A licensed adjuster or attorney at law representing such an insurer from time to time in his professional capacity.

History.

1961, ch. 330, § 245, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in paragraphs (2)(a) through (2)(c) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1202. Representing or aiding unauthorized insurer prohibited — Penalty. — Any person who violates section 41-1201[, Idaho Code,] shall upon conviction thereof be guilty of a misdemeanor punishable by a fine of not to exceed two thousand dollars (\$2,000) or by imprisonment in the county jail for not to exceed six (6) months, or by both such fine and imprisonment in the court's discretion; except, that the court shall increase the amount of any fine so levied by the full amount of any compensation accruing or to accrue to the violator by reason of the acts out of which the violation arose. Each instance of violation shall be considered a separate offense for the purposes of this section.

History.

1961, ch. 330, § 246, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the beginning of the section was added by the compiler to conform to the statutory citation style.

§ 41-1203. Suits by unauthorized insurer prohibited. — (1) No unauthorized insurer shall institute or file, or cause to be instituted or filed, any suit, action or proceeding in this state to enforce any right, claim or demand arising out of any insurance transaction in this state.

(2) This section does not apply as to: (a) Transactions permitted under section 41-306[, Idaho Code,] (exceptions to certificate of authority requirement).

(b) Coverages exempted from the surplus line law under section 41-1212[, Idaho Code].

(c) Counter claim, cross complaint, or similar action by an insurer in connection with a suit brought against the insurer in which service of process on the insurer was made under the unauthorized insurers process act, sections 41-1204 through 41-1210[, Idaho Code].

History.

1961, ch. 330, § 247, p. 645.

STATUTORY NOTES

Cross References.

Surplus line law, § 41-211.

Compiler's Notes.

The bracketed insertions in paragraphs (2)(a) through (2)(c) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1204. Unauthorized insurers process act — Title — Interpretation. — (1) Sections 41-1204 through 41-1210[, Idaho Code,] constitute and may be cited as the unauthorized insurers process act.

(2) Such act shall be so interpreted as to effectuate its general purpose to make uniform the law of those states which enact it.

History.

1961, ch. 330, § 248, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-1205. Purpose of process act. — The purpose of the unauthorized insurers process act is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts.

The legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interest, the legislature herein provides a method of substituted service of process upon such insurers and declares that in so doing it exercises its power to protect its residents and to define, for the purpose of this statute, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of **Public Law 15, 79th Congress** of the United States, chapter 20, 1st session, S. 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

History.

1961, ch. 330, § 249, p. 645.

STATUTORY NOTES

Federal References.

Public Law 15, 79th Congress of the United States, chapter 20, referred to in this section, is compiled as **15 U.S.C.S. §§ 1011 to 1015**.

§ 41-1206. Acts constituting director as process agent. — Any of the following acts in this state, effected by mail or otherwise, by an unauthorized foreign or alien insurer, is equivalent to and shall constitute an appointment by such insurer of the director to be its true and lawful attorney, upon whom may be served all lawful process in any action, suit or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance, and any such act shall be signification of its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon such insurer:

(1) The issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein.

(2) The solicitation of applications for such contracts.

(3) The collection of premiums, membership fees, assessments, or other consideration for such contract, or (4) Any other transaction of insurance business.

History.

1961, ch. 330, § 250, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1207. How process is served — Default judgment. — (1) Such service of process shall be made as provided for in section 41-334(1)[, Idaho Code], and:

(a) The director shall forthwith mail by registered mail one (1) of the copies of such process to the defendant at its last known principal place of business, and shall keep a record of all processes so served upon him.

(b) Such service of process is sufficient, provided (i) notice thereof and (ii) a copy of the process, are sent to the defendant at its last known principal place of business, by the plaintiff or the plaintiff's attorney, by registered mail within ten (10) days thereafter, and provided that on or before the date the defendant is required to appear, or within such further time as the court may allow, there shall be filed with the clerk of the court in which such action is pending (i) the defendant's receipt of registration, or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and (ii) the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith.

(2) Service of process in any such action, suit or proceeding shall, in addition to the manner provided in subsection (1) of this section, be valid if served upon any person within this state who, on behalf of such insurer, is:

(a) Soliciting insurance, or

(b) Making, issuing or delivering any contract of insurance, or

(c) Collecting or receiving any premium, membership fee, assessment or other consideration for insurance; and a copy of such process is sent to the defendant in the same manner as set forth in subsection (1)(b) herein.

(3) No plaintiff or complainant shall be entitled to a judgment by default under this section until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

(4) Nothing contained in this section shall limit or abridge the right to serve any process, notice or demand upon any insurer in any other manner now or hereafter permitted by law.

History.

1961, ch. 330, § 251, p. 645.

STATUTORY NOTES**Compiler's Notes.**

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in the introductory paragraph in subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-1208. Defense of action by unauthorized insurer. — (1) Before any unauthorized foreign or alien insurer shall file or cause to be filed any pleading in any action, suit or proceeding instituted against it, such unauthorized insurer shall:

(a) Deposit with the clerk of the court in which such action, suit or proceeding is pending, cash or securities, or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount determined by the court to be sufficient to secure the payment of any final judgment which may be rendered in such action, provided, however, that the court may in its discretion make an order dispensing with such deposit or bond where the insurer makes a showing satisfactory to such court that it maintains in a state of the United States funds or securities, in trust or otherwise, sufficient and available to satisfy any final judgment which may be entered in such action, suit or proceeding, and that such insurer will pay any final judgment rendered without requiring suit to be brought on such judgment in the state where such securities are located, or

(b) Procure a certificate of authority to transact the business of insurance in this state.

(2) In any action, suit or proceeding in which service is made in the manner provided in section 41-1207[, Idaho Code], the court may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (1) of this section and to defend such action.

(3) Nothing in subsection (1) of this section is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion, in accordance with the applicable rules of civil procedure, to quash a writ or to set aside service thereof made in the manner provided in section 41-1207[, Idaho Code], hereof on the ground either:

(a) That such unauthorized insurer has not done any of the acts enumerated in section 41-1206[, Idaho Code], or

(b) That the person on whom service was made pursuant to subsection (2) of section 41-1207[, Idaho Code,] was not doing any of the acts therein enumerated.

History.

1961, ch. 330, § 252, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in subsections (2) and (3) were added by the compiler to conform to the statutory citation style.

§ 41-1209. Unauthorized insurer failing to pay claim — Attorney fees. — In any action against an unauthorized foreign or alien insurer, upon a contract of insurance issued or delivered in this state to a resident thereof, or to a corporation authorized to do business therein, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Such fee shall not exceed twelve and one-half per cent (12 ½%) of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall such fee be less than twenty-five dollars (\$25.00). Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

History.

1961, ch. 330, § 253, p. 645.

§ 41-1210. Exemptions from process act. — The provisions of this unauthorized insurers process act shall not apply to any action, suit or proceeding against any unauthorized foreign or alien insurer arising out of any contract of:

(1) Reinsurance, ocean marine, aircraft or railway insurance; (2) Insurance effectuated in accordance with the surplus line law or any amendments or supplements thereto; (3) Insurance against legal liability arising out of the ownership, operation or maintenance of any property having a permanent situs outside this state; or (4) Insurance against loss of or damage to any property having a permanent situs outside this state; Where such contract of insurance contains a provision designating the director or a bona fide resident of Idaho to be the true and lawful attorney of such unauthorized insurer upon whom may be served all lawful process in any action, suit or proceeding instituted by or on behalf of an insured or beneficiary arising out of such contract or where the insurer enters a general appearance in any such suit, action or proceeding.

History.

1961, ch. 330, § 254, p. 645.

STATUTORY NOTES

Cross References.

Surplus line law, § 41-1211.

Compiler's Notes.

The unauthorized insurers process act is compiled as §§ 41-1204 to 41-1210. See § 41-1204.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41 to 203).

§ 41-1211. Surplus line law — Short title — Purpose. — (1) Sections 41-1211 through 41-1234, Idaho Code, constitute and may be cited as the “surplus line law.”

(2) It is declared that the purposes of the surplus line law are to provide orderly access for the insuring public of Idaho to insurers not authorized to transact insurance in this state, through only qualified, licensed, and supervised surplus line brokers licensed in Idaho and under such safeguards for the insured as may be practical, for insurance coverages and to the extent thereof not procurable from authorized insurers; to protect such authorized insurers, which under the laws of Idaho must meet certain standards as to policy forms and rates, from unwarranted competition by unauthorized insurers who, in the absence of this law, would not be subject to similar requirements; and for other purposes as set forth in this law.

History.

1961, ch. 330, § 255, p. 645; am. 1993, ch. 22, § 1, p. 79; am. 2002, ch. 91, § 1, p. 227.

STATUTORY NOTES

Effective Dates.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1212. Exemptions from surplus line law. — (1) The provisions of this surplus line law controlling the placing of insurance with unauthorized insurers shall not apply to reinsurance or, except as to subsection (2) below, to the following insurances when so placed by licensed agents or surplus line brokers of this state:

- (a) Ocean marine and foreign trade insurances.
- (b) Insurance on subjects located, resident, or to be performed wholly outside of this state, or on vehicles or aircraft owned and principally garaged outside this state.
- (c) Insurance on operations of railroads engaged in transportation in interstate commerce and their property used in such operations.
- (d) Insurance of aircraft owned or operated by manufacturers of aircraft, or of aircraft operated in commercial scheduled interstate flight, or cargo of such aircraft, or against liability, other than worker's compensation and employer's liability, arising out of the ownership, maintenance or use of such aircraft.

(2) Brokers so placing any such insurance with an unauthorized insurer shall keep a full and true record of each such coverage in detail as required of surplus line insurance under this law. The record shall be preserved for not less than five (5) years from the effective date of the insurance and shall be kept available in this state and open to the examination of the director. The broker shall furnish to the director at his request and on forms as designated and furnished by him a report of all such coverages so placed in a designated calendar year.

(3) The following sections apply only when the insured's home state is Idaho:

- (a) [Section 41-1214, Idaho Code](#) (conditions for export);
- (b) [Section 41-1215, Idaho Code](#) (broker's affidavit);
- (c) [Section 41-1216, Idaho Code](#) (open lines for export);
- (d) [Section 41-1217, Idaho Code](#) (eligible surplus lines insurers);

- (e) [Section 41-1218, Idaho Code](#) (eligible surplus line insurers — penalty for violation);
- (f) [Section 41-1219, Idaho Code](#) (evidence of the insurance — changes — penalty);
- (g) [Section 41-1220, Idaho Code](#) (endorsement of contract);
- (h) [Section 41-1227, Idaho Code](#) (records of broker);
- (i) [Section 41-1228, Idaho Code](#) (annual report of broker);
- (j) [Section 41-1229, Idaho Code](#) (tax on surplus lines);
- (k) [Section 41-1233, Idaho Code](#) (report and tax of independently procured coverages);
- (l) [Section 41-1234, Idaho Code](#) (records of insureds).

History.

1961, ch. 330, § 256, p. 645; am. 1972, ch. 369, § 8, p. 1072; am. 2011, ch. 183, § 1, p. 517.

STATUTORY NOTES

Cross References.

Surplus line law, § 41-1211.

Amendments.

The 2011 amendment, by ch. 183, substituted “worker’s compensation” for “workmen’s compensation” in paragraph (1)(d) and added subsection (3).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1213. Definitions. — As used in this chapter and any applicable rules, the following definitions shall apply:

(1) “Affiliated” means, with respect to an insured, any entity that controls, is controlled by or is under common control with the insured.

(2) “Affiliated group” means any group of entities that are all affiliated.

(3) “Broker” means a surplus line broker duly licensed as such under this chapter, including resident surplus line brokers and nonresident surplus line brokers.

(4) “Control” means:

(a) An entity directly or indirectly, or acting through one (1) or more other persons, owns or controls another entity or has the power to vote twenty-five percent (25%) or more of any class of voting securities of another entity; or

(b) An entity controls in any manner the election of a majority of the directors or trustees of another entity.

(5)(a) “Exempt commercial purchaser” means any person purchasing commercial insurance who, at the time of placement, meets the following requirements:

(i) The person employs or retains a qualified risk manager to negotiate insurance coverage.

(ii) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars (\$100,000) in the immediately preceding twelve (12) months.

(iii) The person meets at least one (1) of the following criteria:

1. The person possesses a net worth in excess of twenty million dollars (\$20,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.

2. The person generates annual revenues in excess of fifty million dollars (\$50,000,000) as such amount is adjusted pursuant to the

provisions of paragraph (b) of this subsection.

3. The person employs more than five hundred (500) full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand (1,000) employees in the aggregate.

4. The person is a nonprofit organization or public entity generating annual budgeted expenditures of at least thirty million dollars (\$30,000,000) as such amount is adjusted pursuant to the provisions of paragraph (b) of this subsection.

5. The person is a municipality with a population in excess of fifty thousand (50,000) persons.

(b) The amounts provided in subparagraph (iii) 1., 2. and 4. of paragraph (a) of this subsection must be adjusted to reflect the percentage change for the five (5) year period in the consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor.

(c) For the purposes of this subsection, “commercial insurance” means property and casualty insurance pertaining to a business, profession, occupation, nonprofit organization or public entity.

(6) “Export” means to place in an unauthorized insurer under this surplus line law insurance covering a subject of insurance resident, located, or to be performed in Idaho.

(7)(a) “Home state” means:

(i) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual’s principal residence; or

(ii) If one hundred percent (100%) of the insured risk is located out of state, the state to which the greatest percentage of the insured’s taxable premium for that insurance contract is allocated.

(b) If more than one (1) insured from an affiliated group are named insureds on a single nonadmitted insurance contract, then “home state” means the home state, as determined pursuant to the provisions of paragraph (a) of this subsection, of the member of the affiliated group

that has the largest percentage of premium attributed to it under such insurance contract.

(c) For the purposes of this subsection, “principal place of business” means the state where the insured maintains its headquarters and where the insured’s high level officers direct, control and coordinate the business activities of the insured.

(8) “Qualified risk manager” means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(a) The person is an employee of, or a third party consultant retained by, the commercial policyholder;

(b) The person provides skilled services in loss prevention, loss reduction or risk and insurance coverage analysis, and purchase of insurance; and

(c) The person:

(i) Has at least ten (10) years of experience in risk financing, claim administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance; or

(ii) Has a graduate degree from an accredited college or university in risk management, business administration, finance, economics or any other field determined by a state insurance director or other state regulatory official or entity to demonstrate minimum competence in risk management; or

(iii) Has at least seven (7) years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis or purchasing commercial lines of insurance and has one (1) of the designations specified in subparagraph (iv)1. through 5. of this paragraph; or

(iv) Has a bachelor’s degree or higher education from an accredited college or university in risk management, business administration, finance, economics or any other field determined by a state insurance director or other state regulatory official or entity to demonstrate minimum competency in risk management; and either has three (3) years of experience in risk financing, claims administration, loss

prevention, risk and insurance analysis or purchasing commercial lines of insurance, or has one (1) of the following designations:

1. A designation as a chartered property and casualty underwriter (CPCU) issued by the American institute for CPCU and insurance institute of America;
2. A designation as an associate in risk management (ARM) issued by the American institute for CPCU and insurance institute of America;
3. A designation as a certified risk manager (CRM) issued by the national alliance for insurance education and research;
4. A designation as a RIMS fellow (RF) issued by the global risk management institute; or
5. Any other designation, certification or license determined by a state insurance director or other state insurance regulatory official or entity to demonstrate minimum competency in risk management.

History.

1961, ch. 330, § 257, p. 645; am. 2002, ch. 91, § 2, p. 227; am. 2011, ch. 183, § 2, p. 517.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 183, added the introductory language; added subsections (1) and (2); redesignated former subsection (1) as subsection (3), and therein deleted “as used in this chapter” following “Broker”; added subsection (4); redesignated former subsection (2) as subsection (6), and therein substituted “Export” for “To ‘export’”; and added subsections (7) and (8).

Compiler’s Notes.

For more on the consumer price index for all urban consumers, referred to in paragraph (5)(b), see <https://www.bls.gov/news.release/cpi.t05.htm>.

The American institute for CPCU and the insurance institute of America, referred to in paragraph (8)(c)(iv), were rebranded in 2009 as The Institutes.

See <https://www.theinstitutes.org/>.

Effective Dates.

Section 14 of S.L. 2002, ch. 91, declared an emergency. Approved March 19, 2002.

§ 41-1214. Conditions for export. — If certain insurance coverages cannot be procured from authorized insurers, such coverages, hereinafter designated “surplus lines,” may be procured from unauthorized insurers, subject to the following conditions:

(1) The insurance must be procured through a licensed surplus line broker who is a member of a surplus line association approved by the director.

(2) The full amount or kind of insurance required must not be procurable from insurers who are authorized to do business in this state. The amount of insurance exported shall be only the excess over the amount procurable from authorized insurers unless the excess is not available without support of other coverages, provided that a diligent search is made among the insurers authorized to transact and actually writing that particular kind and class of insurance in this state.

(3) The insurance must not be so exported for the purpose of securing advantages either as to:

(a) A lower premium rate than would be accepted by an authorized insurer; or

(b) Terms of the insurance contract.

(4) A surplus line broker seeking to procure from or place insurance with an unauthorized insurer for an exempt commercial purchaser is not required to satisfy the diligent search requirement set forth in subsection (2) of this section when:

(a) The surplus line broker or referring insurance producer procuring or placing the surplus line insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(b) The exempt commercial purchaser has subsequently requested in writing the surplus line broker or referring insurance producer to procure or place such insurance from an unauthorized insurer.

(5) Records of the surplus line broker's satisfaction of the requirements of subsection (4) of this section shall be maintained in compliance with the provisions of [section 41-1227, Idaho Code](#).

(6) A surplus line broker may not knowingly place surplus line insurance with insurers that are financially unsound. The surplus line broker may only so insure with the following:

(a) Any foreign insurer that is authorized to write the kind of insurance in its domiciliary jurisdiction and has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction that equals the greater of the following: (i) the minimum capital and surplus requirements under the laws of this state; or (ii) fifteen million dollars (\$15,000,000); or

(b) Any alien insurer that is listed on the quarterly listing of alien insurers maintained by the international insurers department of the national association of insurance commissioners.

(7) The requirements in paragraph (a) of subsection (6) of this section may be satisfied by an insurer that possesses less than the minimum capital and surplus upon an affirmative finding of acceptability by the director. Such finding shall be based upon factors such as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. The director is prohibited from making an affirmative finding of acceptability when the foreign insurer's capital and surplus is less than four million five hundred thousand dollars (\$4,500,000).

(8) The director may promulgate rules to prescribe the terms under which the financial requirements provided in this section may be waived in circumstances where insurance cannot be otherwise procured on risks located in this state.

(9) For any violation of the provisions of this section, a surplus line broker may be subject to a fine of not less than one hundred dollars (\$100) and not more than five thousand dollars (\$5,000), or the surplus line broker's license may be revoked, suspended or nonrenewed, or both such fine and license revocation, suspension or nonrenewal.

History.

1961, ch. 330, § 258, p. 645; am. 1993, ch. 22, § 2, p. 79; am. 2011, ch. 183, § 3, p. 517.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 183, added subsections (4) through (9).

Compiler's Notes.

For further information on the national association of insurance commissioners, referred to in paragraph (6)(b), see *<http://naic.org/>*.

§ 41-1215. Broker's affidavit. — At the time of procuring any such surplus line insurance the broker shall execute an affidavit, in form as prescribed or accepted by the director, setting forth facts from which it can be determined whether such insurance was eligible for export under [section 41-1214, Idaho Code](#). The broker shall file, or cause to be filed, this affidavit with the director within thirty (30) days after the insurance policy is received by the broker.

History.

1961, ch. 330, § 259, p. 645; am. 1993, ch. 22, § 3, p. 79; am. 2002, ch. 91, § 3, p. 227.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1216. Open lines for export. — (1) The director may by order or by rule declare eligible for export generally and without compliance with the provisions of sections 41-1214(2), 41-1214(3) and 41-1215, Idaho Code, any class or classes of insurance coverage or risk which he finds, consistent with the procedural requirements of chapter 52, title 67, Idaho Code, that there is no reasonable or adequate market among authorized insurers either as to acceptance of the risk, contract terms, or premium or premium rate. Any such order shall continue in effect during the existence of the conditions upon which predicated, but subject to earlier termination by the director.

(2) The broker shall file with or as directed by the director a memorandum as to each such coverage placed by him in an unauthorized insurer, in such form and context as the director may reasonably require for the identification of the coverage and determination of the tax payable to the state relative thereto.

(3) The broker, or a licensed Idaho agent of the authorized insurer, may also place with authorized insurers any insurance coverage made eligible for export generally under subsection (1) of this section and without regard to rate or form filings which may otherwise be applicable as to the authorized insurer. As to coverages so placed in an authorized insurer the premium tax thereon shall be reported and paid by the insurer as required generally under [section 41-402, Idaho Code](#).

History.

1961, ch. 330, § 260, p. 645; am. 2002, ch. 91, § 4, p. 227.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1217. Eligible surplus lines insurers. — (1) A broker shall not knowingly place surplus lines insurance with an insurer that is unsound financially, or that is ineligible under this section.

(2) The director shall from time to time compile or approve a list of all surplus lines insurers deemed by him to be eligible currently, and shall cause to be sent a copy of such list to each broker at his office last of record with the director. This subsection shall not be deemed to require the director to determine the actual financial condition or claims practices of any unauthorized insurer; and the status of eligibility, if granted by the director, shall indicate only that the insurer appears to be sound financially and to have satisfactory claims practices, and that the director has no credible evidence to the contrary. While any such list is in effect the broker shall restrict to the insurers so listed all surplus lines business placed by him and a person who independently procures its own insurance pursuant to this chapter for risks located in Idaho shall only purchase surplus line insurance from insurers so listed.

(3) An eligible surplus lines insurer shall notify the director of any change to the name of the insurer, its physical or mailing address, or its state of domicile, within sixty (60) days of such change.

History.

1961, ch. 330, § 261, p. 645; am. 1969, ch. 214, § 39, p. 625; am. 1997, ch. 108, § 1, p. 252; am. 2002, ch. 91, § 5, p. 227; am. 2004, ch. 87, § 1, p. 322.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1218. Eligible surplus line insurers — Penalty for violation. —

(1) For any violation of [section 41-1217, Idaho Code](#), the broker or a person who independently procures its own insurance shall, upon conviction thereof, be guilty of a misdemeanor punishable as provided in [section 41-117, Idaho Code](#) (general penalty).

(2) The director may impose an administrative penalty not to exceed fifteen thousand dollars (\$15,000), for deposit in the general account [fund] of the state of Idaho, upon any person or entity who transacts or who attempts to transact insurance as a surplus lines insurer in violation of any provision of chapter 12, title 41, Idaho Code. Failure of any such person or entity to pay a fine imposed pursuant to the provisions of this section shall authorize the director to seek enforcement of the fine, and any associated costs and attorney's fees related to bringing the action, in any district court of this state.

History.

1961, ch. 330, § 262, p. 645; am. 1993, ch. 22, § 4, p. 79; am. 2002, ch. 91, § 6, p. 227; am. 2005, ch. 267, § 1, p. 828.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in the first sentence in subsection (2) was added by the compiler to correct the name of the referenced fund. See § 67-1205.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1219. Evidence of the insurance — Changes — Penalty. — (1)

Upon placing a surplus line coverage, the broker shall promptly issue and deliver to the insured evidence of the insurance consisting either of the policy as issued by the insurer or, if such policy is not then available, a certificate showing the description and location of the subject of the insurance, coverage, conditions and term of the insurance, the premium and rate charged and taxes collected from the insured, and the name and address of the insured and insurer. If the direct risk is assumed by more than one insurer, the certificate shall state the name and address and proportion of the entire direct risk assumed by each such insurer.

(2) No broker shall issue any such certificate or any cover note, or purport to insure or represent that insurance will be or has been granted by any unauthorized insurer, unless he has prior written authority from the insurer for the insurance, or has received information from the insurer in the regular course of business that such insurance has been granted, or an insurance policy providing the insurance actually has been issued by the insurer and delivered to the insured.

(3) If after the issuance and delivery of any such certificate there is any change as to the identity of the insurers, or the proportion of the direct risk assumed by an insurer as stated in the broker's original certificate, or in any other material respect as to the insurance coverage evidenced by the certificate, the broker shall promptly issue and deliver to the insured a substitute certificate accurately showing the current status of the coverage and the insurers responsible thereunder.

(4) If a policy issued by the insurer is not available upon placement of the insurance and the broker has issued and delivered his certificate as hereinabove provided, upon request therefor by the insured the broker shall as soon as reasonably possible procure from the insurer its policy evidencing such insurance and deliver such policy to the insured in replacement of the broker's certificate theretofore issued.

(5) Any surplus line broker who knowingly issues a false certificate of insurance, or who knowingly fails promptly to notify the insured of any material change with respect to such insurance by delivery to the insured of

a substitute certificate as provided in subsection (3) of this section, shall upon conviction, be subject to the penalties provided by [section 41-117, Idaho Code](#), or to any greater applicable penalty otherwise provided by law.

History.

1961, ch. 330, § 263, p. 645; am. 1997, ch. 108, § 2, p. 252.

§ 41-1220. Endorsement of contract. — Every insurance contract procured and delivered as a surplus lines coverage pursuant to this law shall have stamped upon it, either in red ink with at least ten (10) point bold print or in black ink with at least twelve (12) point bold print, and bear the name of the surplus lines broker who procured it, the following:

“This surplus line contract is issued pursuant to the Idaho insurance laws by an insurer not licensed by the Idaho Department of Insurance. There is no coverage provided for surplus line insurance by either the Idaho Insurance Guaranty Association or by the Idaho Life and Health Insurance Guaranty Association.”

History.

1961, ch. 330, § 264, p. 645; am. 1969, ch. 214, § 40, p. 625; am. 1993, ch. 22, § 5, p. 79; am. 2010, ch. 164, § 1, p. 338.

STATUTORY NOTES

Amendments.

The 2010 amendment, by ch. 164, in the first paragraph, inserted “either” and “or in black ink with at least twelve (12) point bold print.”

§ 41-1221. Surplus line insurance valid. — Insurance contracts procured as surplus line coverage from unauthorized insurers in accordance with this law shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers.

History.

1961, ch. 330, § 265, p. 645.

§ 41-1222. Liability of insurer as to losses and unearned premiums.

— (1) As to a surplus line risk which has been assumed by an unauthorized insurer pursuant to this surplus line insurance law, and if the premium thereon has been received by the surplus line broker who placed such insurance, in all questions thereafter arising under the coverage as between the insurer and the insured the insurer shall be deemed to have received the premium due to it for such coverage; and the insurer shall be liable to the insured as to losses covered by such insurance, and for unearned premiums which may become payable to the insured upon cancellation of such insurance, whether or not in fact the broker is indebted to the insurer with respect to such insurance or for any other cause.

(2) Each unauthorized insurer assuming a surplus line direct risk under this surplus lines insurance law shall be deemed thereby to have subjected itself to the terms of this section.

History.

1961, ch. 330, § 266, p. 645.

STATUTORY NOTES

Cross References.

Surplus line law, § 41-1211.

§ 41-1223. Licensing of surplus line brokers. — (1) Any individual while licensed as a producer licensed for property or casualty insurance who has had at least two (2) years' experience as a producer for the lines of insurance for which he is seeking to be licensed as a surplus line broker, and who is deemed by the director to be competent and trustworthy with respect to the handling of surplus lines, may be licensed as a surplus line broker.

(2) Application for the license shall be made to the director on forms as designated and furnished by the director.

(3) The license and continuation fee shall be as set forth by rule pursuant to **section 41-401, Idaho Code**.

(4) The license and licensee shall be subject to the applicable provisions of chapter 10, title 41, Idaho Code (producer licensing).

(5) When a national insurance producer database of the national association of insurance commissioners, or other equivalent uniform national database, for the licensure of surplus line brokers is created, the director may participate in such database.

History.

1961, ch. 330, § 267, p. 645; am. 1972, ch. 164, § 3, p. 376; 1976, ch. 118, § 3, p. 456; am. 2001, ch. 296, § 5, p. 1044; am. 2002, ch. 91, § 7, p. 227; am. 2011, ch. 183, § 4, p. 517.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 183, added subsection (5).

Compiler's Notes.

For further information on the national association of insurance commissioners, referred to in subsection (5), see <http://naic.org/>.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 8 of S.L. 1972, ch. 164 provided the act should take effect from and after January 1, 1973.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1224. Suspension or revocation of broker's license. — (1) The director may suspend or revoke any surplus line broker's license:

(a) If the broker fails to file his annual report or to remit the tax as required by this law; or (b) If the broker fails to keep the records, or to allow the director to examine his records in this state as required by this law; or (c) If the broker knowingly places a surplus line coverage in an insurer that is in unsound financial condition in violation of [section 41-1217, Idaho Code](#); or (d) For any other applicable cause for which a producer's license may be suspended or revoked.

(2) The procedures provided by chapter 10, title 41, Idaho Code, for suspension or revocation of licenses shall apply to suspension or revocation of a surplus line broker's license.

(3) Upon suspending or revoking the broker's surplus line license the director shall also suspend or revoke all other licenses of the same individual under this code.

(4) No broker whose license has been so suspended or revoked shall again be so licensed until any fines or delinquent taxes owing by him have been paid, nor, in case of revocation, until after expiration of one (1) year from date revocation became final.

History.

1961, ch. 330, § 268, p. 645; am. 1972, ch. 164, § 4, p. 376; am. 1997, ch. 108, § 3, p. 252; am. 2002, ch. 91, § 8, p. 227.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 8 of S.L. 1972, ch. 164 provided the act should take effect from and after January 1, 1973.

Section 14 of S.L. 2002, ch. 91, declared an emergency. Approved March 19, 2002.

§ 41-1225. Broker's bond. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 269, p. 645; am. 1997, ch. 108, § 4, p. 252, was repealed by S.L. 2002, ch. 91, § 9, effective March 19, 2002.

§ 41-1226. Acceptance of business from agents. — A licensed surplus line broker may accept and place surplus line business for any insurance agent licensed in this state for the kind of insurance involved, and may compensate the agent therefor.

History.

1961, ch. 330, § 270, p. 645.

§ 41-1227. Records of broker. — (1) Each broker shall keep in his office a full and true record of each surplus line coverage procured by him, including a copy of each daily report, if any, a copy of each certificate of insurance issued by him, and such of the following items as may be applicable:

(a) Amount of the insurance; (b) Gross premium charged;

(c) Return premium paid, if any; (d) Rate of premium charged upon the several items of property; (e) Effective date of the contract, and the terms thereof; (f) Name and address of each insurer on the direct risk and the proportion of the entire risk assumed by such insurer if less than the entire risk; (g) Name and address of the insured; (h) Brief general description of the property of risk injured and where located or to be performed; and (i) Other information as may be required by the director.

(2) The record shall at all times within five (5) years after issuance of the coverage to which it relates be open to examination in this state by the director.

History.

1961, ch. 330, § 271, p. 645; am. 2002, ch. 91, § 10, p. 227.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1228. Annual report of broker. — (1) Each broker shall on or before the first day of March of each year file with the director a verified report of all surplus line insurance transacted by him during the preceding calendar year.

(2) The statement shall be on forms as prescribed and furnished by the director and shall show: (a) Gross amount of each kind of insurance transacted; (b) Aggregate gross premiums charged; (c) Aggregate of returned premiums paid to insureds; (d) Aggregate of net premiums; and (e) Additional information as required by the director.

History.

1961, ch. 330, § 272, p. 645; am. 2002, ch. 91, § 11, p. 227.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1229. Tax on surplus lines. — (1) On or before the first day of March of each year, each broker shall remit to the director a tax on the premiums, exclusive of sums collected to cover federal and state taxes and examination fees, on surplus line insurance subject to tax transacted by him with unauthorized insurers during the preceding calendar year as shown by his annual statement filed with the director, and at the rate of one and five-tenths percent (1.5%). Such tax shall be in lieu of all other taxes upon such insurers with respect to the business so reported.

(2) For property and casualty insurance other than worker's compensation insurance, if Idaho is the insured's home state, then the tax so payable shall be computed upon the entire premium under subsection (1) of this section, without regard to whether the policy covers risks or exposures that are located in Idaho. For all other lines of insurance, if a surplus line policy covers risks or exposures only partially in Idaho, the tax so payable shall be computed upon the proportion of the premium that is properly allocable to the risks or exposures located in Idaho.

(3) Each broker shall round to the nearest whole dollar any amount shown or required to be shown on any return, form, statement, or other document submitted to the director or to any entity set forth in rule pursuant to [section 41-1232, Idaho Code](#). Any record or other document prepared or maintained by the director shall express any dollar amount rounded to the nearest whole dollar.

History.

1961, ch. 330, § 273, p. 645; am. 1988, ch. 186, § 1, p. 325; am. 1988, ch. 366, § 4, p. 1077; am. 1994, ch. 383, § 3, p. 1229; am. 2004, ch. 387, § 1, p. 1163; am. 2011, ch. 183, § 5, p. 517; am. 2019, ch. 45, § 2, p. 124.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 183, in subsection (1), substituted “and at the rate of one and five-tenths percent (1.5%)” for “and at the following rates” and deleted paragraphs (1)(a) and (1)(b), which concerned calendar

years 2004 through 2007; and rewrote subsection (2), which formerly read: “If a surplus line policy covers risks or exposure only partially in this state, the tax so payable shall be computed upon the proportion of the premium which is properly allocable to the risks or exposures located in this state.”

The 2019 amendment, by ch. 45, added subsection (3).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 8 of S.L. 1988, ch. 366 read: “An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2, 3, 5, 6 and 7 of this act shall be in full force and effect on and after passage and approval, and retroactively to January 1, 1988; and Section 4 of this act shall be in full force and effect on and after passage and approval, and retroactively to January 1, 1987.” Approved April 6, 1988.

Section 4 of S.L. 1994, ch. 383 provided that this act shall be in full force and effect on and after January 1, 1995.

Section 6 of S.L. 2011, ch. 183 provided that the amendment of § 41-1229 should take effect on and after July 21, 2011.

§ 41-1230. Failure to file report or remit tax — Penalty. — If any broker fails to file his annual report, or fails to remit the tax provided by [section 41-1229, Idaho Code](#), prior to the first day of April after the tax is due, he shall be liable for a fine of twenty-five dollars (\$25.00) for each day of delinquency commencing with the first day of April. The tax may be collected by distraint, or the tax and fine may be recovered by an action instituted by the director in any court of competent jurisdiction. Any fine collected by the director shall be paid to the state treasurer and credited to the general fund.

History.

1961, ch. 330, § 274, p. 645; am. 2002, ch. 91, § 12, p. 227.

STATUTORY NOTES

Cross References.

General fund, § 67-1205.

State treasurer, § 67-1201 et seq.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 14 of S.L. 2002, ch. 91, declared an emergency. Approved March 19, 2002.

§ 41-1231. Legal process against surplus line insurer. — (1) An unauthorized insurer shall be sued, upon any cause of action arising in this state under any contract issued by it as a surplus line contract pursuant to this law, in the district court of the county in which the cause of action arose.

(2) Service of legal process against the insurer may be made in any such action by service upon the director as provided in section 41-334(1)[, Idaho Code]. The director shall forthwith mail a copy of the process served to the person designated by the insurer in the policy for the purpose, by prepaid registered mail with return receipt requested. The insurer shall have thirty (30) days from the date of service upon the director within which to plead, answer, or otherwise defend the action. Upon service of process upon the director in accordance with this provision, the court shall be deemed to have jurisdiction in personam of the insurer.

(3) An unauthorized insurer issuing such policy shall be deemed thereby to have authorized service of process against it in the manner and to the effect as provided in this section. Any such policy shall contain a provision stating the substance of this section, and designating the person to whom the director shall mail process as provided in subsection (2) of this section.

History.

1961, ch. 330, § 275, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in the first sentence in subsection (2) was added by the compiler to conform to the statutory citation style.

§ 41-1232. Rules and regulations. — (1) The director shall make or may approve and adopt reasonable rules and regulations, consistent with this surplus lines law, for any or all of the following purposes:

(a) Effectuation of such law; (b) Establishment of procedures through which determination is to be made as to the eligibility of particular proposed coverages for export; and (c) Establishment, procedures, and operations of any organization of brokers or others designed to assist such brokers to comply with such law. The director may delegate to such an organization the responsibility, under his general supervision, for the determination of the eligibility for export of particular proposed coverages; and (d) Regulation of the fees and charges to be required of the insured in addition to the premium as fixed by the insurer.

(2) Such rules and regulations shall be subject to the procedures and carry the penalty provided by [section 41-211, Idaho Code](#), (rules and regulations).

History.

1961, ch. 330, § 276, p. 645; am. 1969, ch. 214, § 41, p. 625; am. 1993, ch. 22, § 6, p. 79.

STATUTORY NOTES

Cross References.

Surplus line law, § 41-1211.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1233. Report and tax of independently procured coverages. —

(1) Every insured who in this state procures or causes to be procured or continues or renews insurance in an unauthorized foreign insurer, or any self-insurer who in this state so procures or continues excess loss, catastrophe or other insurance, upon a subject of insurance resident, located or to be performed within this state, other than insurance procured through a surplus line broker pursuant to the surplus line law of this state or exempted from tax pursuant to [section 41-1212, Idaho Code](#), shall within thirty (30) days after the date such insurance policy was so received by the insured, continued or renewed file a written report of the same with the surplus line association on forms designated by the director and furnished to the insured upon request. The report shall show the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged therefor, and such additional pertinent information as the director reasonably requests. If the insurance covers also a subject of insurance resident, located or to be performed outside this state a proper pro rata portion of the entire premium payable for all such insurance shall be allocated to this state for the purposes of this section.

(2) Any insurance in an unauthorized insurer procured through negotiations or an application in whole or in part occurring or made within or from within this state, or for which premiums in whole or in part are remitted directly or indirectly from within this state, shall be deemed to be insurance procured or continued or renewed in this state within the intent of subsection (1) of this section.

(3) The insured with respect to the obligation, chose in action, or right represented by such insurance shall be subject to [section 41-1229, Idaho Code](#), as it pertains to premium tax. Within thirty (30) days after the insurance policy was so received by the insured, continued or renewed, and coincidentally with the filing with the surplus line association of the report provided for in subsection (1) of this section, the insured shall pay the amount of the tax to the director and a stamping fee to the surplus line association.

(4) The tax imposed hereunder if delinquent shall bear interest at the rate of six percent (6%) per annum, compounded annually.

(5) The tax shall be collectible from the insured by civil action brought by the director, or by distraint.

(6) This section does not abrogate or modify any provision of sections 41-1201 (representing or aiding unauthorized insurer prohibited), 41-1202 (representing or aiding unauthorized insurer prohibited — penalty), or 41-1203 (suits by unauthorized insurer prohibited), Idaho Code.

(7) This section does not apply as to life or disability insurances.

History.

1961, ch. 330, § 277, p. 645; am. 1988, ch. 366, § 5, p. 1077; am. 1993, ch. 22, § 7, p. 79; am. 2002, ch. 91, § 13, p. 227; am. 2004, ch. 387, § 2, p. 1163.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 8 of S.L. 1988, ch. 366 read: “An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2, 3, 5, 6 and 7 of this act shall be in full force and effect on and after passage and approval, and retroactively to January 1, 1988; and Section 4 of this act shall be in full force and effect on and after passage and approval, and retroactively to January 1, 1987.” Approved April 6, 1988.

Section 14 of S.L. 2002, ch. 91 declared an emergency. Approved March 19, 2002.

§ 41-1234. Records of insureds. — In order that the director may effectively administer the various provisions of this chapter, every person as to whom insurance has been placed with an unauthorized insurer shall, upon the director's order, produce for his examination all policies and other documents evidencing the insurance, and shall disclose to the director the amount of premiums paid or agreed to be paid for the insurance. For each refusal to obey such order such person shall, upon conviction thereof, be guilty of a misdemeanor punishable by a fine of not more than five hundred dollars (\$500).

History.

1961, ch. 330, § 278, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1235. False advertising act. — Sections 41-1235 through 41-1237[, Idaho Code,] of this act constitute and may be referred to as the unauthorized insurers false advertising process act.

History.

I.C., § 41-1235, as added by 1969, ch. 214, § 42, p. 625.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion was added by the compiler to conform to the statutory citation style.

§ 41-1236. Misrepresentation by unauthorized insurer. — No unauthorized insurer through any estimate, illustration, circular, pamphlet, letter, announcement, statement or any other means or medium shall misrepresent to any person in this state its financial condition or the terms of any contract issued or to be issued by it or the advantages thereof, or the dividends or share to be received thereon. Whenever the director has reason to believe that any such insurer is so misrepresenting, he shall notify the insurer and the insurance supervisory officer of the insurer's domiciliary state or province by registered or certified mail.

History.

I.C., § 41-1236, as added by 1969, ch. 214, § 43, p. 625.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1237. Misrepresentation — Action and penalties. — (1) If within twenty-one (21) days following the giving of the notice provided for in [section 41-1236, Idaho Code](#), the insurer has not ceased such dissemination, and if the director has reason to believe that such insurer is soliciting, issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or performing any other transaction in connection with such insurance, and that a proceeding by him in respect to such matters would be in the interest of the public, he shall order the insurer to desist the prohibited practices.

(2) If the director finds that the insurer has misrepresented as referred to in [section 41-1236, Idaho Code](#), he shall by order on such hearing require the insurer to cease and desist from such violation, and shall mail a copy of the order by registered or certified mail to the insurer at its principal place of business last of record with the director and to the insurance supervisory officer of the insurer's domiciliary state or province. Each violation thereafter of such desist order shall subject the insurer to a penalty of two thousand dollars (\$2,000), to be recovered by a civil action brought against the insurer by the director. Service of process upon the insurer in such action may be made upon the director pursuant to [section 41-1207, Idaho Code](#), or in any other lawful manner.

History.

[I.C., § 41-1237](#), as added by 1969, ch. 214, § 44, p. 625; am. 2005, ch. 78, § 2, p. 78.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Chapter 13

TRADE PRACTICES AND FRAUDS

Sec.

41-1301. Purposes of trade practices law.

41-1302. Unfair methods of competition and deceptive act prohibited.

41-1303. Misrepresentation or false advertising of policies.

41-1304. False information and advertising with respect to insurance business.

41-1305. “Twisting” prohibited.

41-1306. False financial statements.

41-1307. Representations as to assets or financial condition — Assessment plan to be stated in advertising.

41-1308. Defamation.

41-1309. Boycott, coercion and intimidation.

41-1310. Person financing purchase of property not to favor insurer or agent.

41-1311. Seller of property not to favor insurer or agent.

41-1312. Rights with respect to insurance on property sold or purchased.

41-1313. Unfair discrimination — Life insurance, annuities, and disability insurance.

41-1314. Rebates — Illegal inducements.

41-1315. Exceptions to discrimination or rebate provision — Life or disability policies, and annuity contracts.

41-1315A. Discounts to employees.

41-1316. Stock operations and advisory board contracts.

41-1317. Fictitious groups.

41-1318. Interlocking ownership or management.

41-1319. Desist orders for prohibited practices. [Repealed.]

41-1320. Service of notices and processes. [Repealed.]

41-1321. Procedures as to undefined practices.

41-1322. Appeal by intervenor. [Repealed.]

41-1323. Illegal dealing in premiums — Excess charges for insurance.

41-1324. Report of exact consideration to insurer.

41-1325. Borrowing money from clients.

41-1326. [Amended and Redesignated.]

41-1327. Violations — Penalty.

41-1328. Payment of claims by insurers.

41-1328A. Repair of motor vehicles.

41-1328B. Definitions.

41-1328C. Identification of parts.

41-1328D. Use of parts — Disclosure.

41-1329. Unfair claim settlement practices.

41-1329A. Unfair claims settlement practices — Penalty.

41-1330. Failure to maintain complaint handling procedures.

41-1331. Claims forms statement.

41-1332. Return of unearned premium for disability policies.

41-1333. Refund of unearned health insurance premiums.

41-1334. Disclosure of nonpublic personal information.

41-1335. Release of patient identifiable prescription information prohibited
— Exceptions.

41-1336. Requirements for compliance.

41-1337. Life insurance — Payment of interest on benefits.

41-1338. Uninsured vehicle tracking — Penalties.

§ 41-1301. Purposes of trade practices law. — The purpose of [sections 41-1301 through 41-1321, Idaho Code](#), is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of congress of March 9, 1945 ([Public Law 15, 79th Congress](#) [ch. 20, 59 U.S. Stat. at Large 33]), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

History.

1961, ch. 330, § 279, p. 645; am. 2005, ch. 77, § 6, p. 258.

STATUTORY NOTES

Federal References.

Act of congress of March 9, 1945 ([Public Law 15, 79th Congress](#)), referred to in this section, is compiled as [15 U.S.C. §§ 1011 to 1015](#).

CASE NOTES

[Customary practices.](#)

[Legislative intent.](#)

[Customary Practices.](#)

A violation of this chapter does not, as a matter of law, constitute fraud, but evidence of an extreme deviation from customary practices is relevant to the state of mind that is necessary to establish fraud. [Walston v. Monumental Life Ins. Co., 129 Idaho 211, 923 P.2d 456 \(1996\)](#).

[Legislative Intent.](#)

The intent of the insurance code is to prohibit unfair business practice and cut-throat competition in the insurance business in order to maintain a healthy and viable industry. [Cox v. Department of Ins., 121 Idaho 143, 823 P.2d 177 \(Ct. App. 1991\)](#).

Cited *Idaho v. Bunker Hill Co.*, 647 F. Supp. 1064 (D. Idaho 1986).

RESEARCH REFERENCES

ALR. — Construction and effect of state statute forbidding unfair trade practice or competition by discrimination, allowance of rebates, commissions, discounts, or the like. 41 *A.L.R.4th* 675.

What constitutes false, misleading, or deceptive advertising or promotional practices subject to action by *Federal Trade Commission*. 34 *A.L.R. Fed.* 507.

§ 41-1302. Unfair methods of competition and deceptive act prohibited. — (1) No person shall engage in this state in any trade practice which is prohibited in this chapter, or defined in this chapter as, or determined pursuant to this chapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

(2) No person shall engage in dishonest or predatory insurance practices in marketing or sales of insurance to service members of the United States armed forces. Notwithstanding any other provision of title 41, Idaho Code, the director may promulgate rules to define dishonest, unfair, deceptive or predatory military sales practices.

History.

1961, ch. 330, § 280, p. 645; am. 2007, ch. 271, § 1, p. 798.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 271, added the subsection (1) designation and subsection (2).

§ 41-1303. Misrepresentation or false advertising of policies. — (1) No person shall make, issue, circulate, or cause to be made, issued, or circulated, any estimate, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title of any policy or class of policies misrepresenting the true nature thereof.

(2) No person shall misrepresent a policy for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.

(3) No person shall misrepresent any insurance policy as being shares of stock.

(4) For reasonable cause the director may in his discretion require any insurer or agent using or proposing to use in this state a prospectus, offering sheet, or other sales literature or printed sales aids in the solicitation of life or disability insurance to file the same with him for review. The director shall forthwith by order disapprove any such prospectus, sheet, literature, or aid found by him to be in violation of this section. The order shall become effective on the effective date specified therein, which date shall not be less than ten (10) days after the date the order was issued and mailed to the insurer or agent affected thereby; except, that if the insurer or agent prior to such effective date makes written request to the director for a hearing relative to the matter the director's order shall thereby be stayed pending the hearing and the director's further order on hearing. No insurer, agent, or other representative shall use in this state any prospectus, offering sheet, literature or sales aid after the date an order of disapproval thereof has become effective and has been communicated to the insurer. This provision shall not relieve any person of liability for penalties provided for violation of subsection (1) above.

History.

1961, ch. 330, § 281, p. 645; am. 1977, ch. 218, § 1, p. 654.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1304. False information and advertising with respect to insurance business. — No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, any advertisement, announcement, or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

History.

1961, ch. 330, § 282, p. 645.

§ 41-1305. “Twisting” prohibited. — No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, surrender, lease, retain, exchange, or convert, or otherwise use or dispose of any insurance policy, or any right or option thereunder, or in connection with any such statement and for like purpose fail to disclose all reasonably material facts, or a material fact necessary to make the statements made, in the light of the circumstances under which they are made, not misleading.

History.

1961, ch. 330, § 283, p. 645; am. 1969, ch. 214, § 45, p. 625.

§ 41-1306. False financial statements. — (1) No person shall file with any supervisory or other public official, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive.

(2) No person shall make any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omit to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

History.

1961, ch. 330, § 284, p. 645.

§ 41-1307. Representations as to assets or financial condition — Assessment plan to be stated in advertising. — (1) No insurer or representative thereof shall anywhere publish, represent or advertise assets except those actually owned and possessed by it in its own exclusive right, available for the payment of losses and claims, and held for the protection of its policy holders and creditors.

(2) Every advertisement or public announcement, and every sign, circular or card issued by any insurer or representative thereof purporting to show its financial condition, shall correspond with or include the most recent verified financial statement of the insurer as filed with the director or with other appropriate governmental authority.

(3) Every insurer transacting insurance in this state on the assessment plan under other express provisions of this code, shall have conspicuously printed in bold face type in every advertisement and advertising document published or used in this state the words “assessment plan”; and shall have the same information clearly conveyed in every advertisement disseminated by radio, television, or similar media.

History.

1961, ch. 330, § 285, p. 645.

STATUTORY NOTES

Cross References.

Assessment plan, statement on policy, § 41-1816.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1308. Defamation. — No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, or of an organization proposing to become an insurer, and which is circulated to injure any person engaged or proposing to engage in the business of insurance.

History.

1961, ch. 330, § 286, p. 645.

§ 41-1309. Boycott, coercion and intimidation. — No person or persons shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

History.

1961, ch. 330, § 287, p. 645.

§ 41-1310. Person financing purchase of property not to favor insurer or agent. — No person engaged in the business of financing the purchase of real or personal property and no trustee, director, officer, agent or other employee of any such person shall require, as a condition to financing the purchase of such property or to loaning money upon the security of a mortgage thereon, or, as a condition for the renewal or extension of any such loan or mortgage or for the performance of any other act in connection therewith, that the person for whom such purchase is to be financed or to whom the money is to be loaned or for whom such extension, renewal or other act is to be granted or performed, purchase or place fire, property damage, theft, collision or personal injury insurance which is required to be maintained by him on the mortgaged property, from or through any particular insurance agent or agents, broker or brokers, or insurer or insurers.

History.

1961, ch. 330, § 288, p. 645.

§ 41-1311. Seller of property not to favor insurer or agent. — No seller of real or personal property, and no person engaged in the business of selling real or personal property, and no trustee, director, officer, agent or other employee of any such seller or such other person shall require, as a condition to the selling of such property, or for the performance of any other act in connection therewith, that the person to whom such property is to be sold, purchase or place any fire, property damage, theft, collision or personal injury insurance covering such property, from any particular insurance agent or agents, broker or brokers, or insurer or insurers.

History.

1961, ch. 330, § 289, p. 645.

§ 41-1312. Rights with respect to insurance on property sold or purchased. — Sections 41-1310 or 41-1311[, Idaho Code,] shall not prevent:

(1) The reasonable exercise by any person engaged in any such business of his right to approve or disapprove the insurance or the insurer selected to write the insurance, on reasonable grounds related to the risk selection or underwriting practices of the insurer, the adequacy and terms of the coverage with respect to the interest of such person to be insured thereunder, the quality of service rendered by the insurer or its representative in connection with the insurance, and the financial standards to be met by the insurer; nor of his right to furnish such insurance or to renew any insurance required by the contract of sale or mortgage, trust deed or other loan agreement if the borrower or purchaser has failed to furnish the insurance or renewal thereof within such reasonable time or form as may be specified in the sale or loan agreement. The lender or vendor shall not refuse to accept insurance provided by an acceptable insurer on the ground that such insurance provides more coverage than is required in the sale or loan agreement, unless the additional coverage consists of life or disability insurance.

(2) The free choice of insurance agent or broker by any borrower or purchaser at any time, and he may revoke any designation of insurance agent or broker at any time irrespective of the provisions of any loan or purchase agreement, mortgage, or trust deed.

(3) The exercise by any person engaged in such business of his right to furnish such insurance or to renew such insurance, and to charge the account of the borrower or purchaser with the costs thereof, if the borrower or purchaser fails to deliver to the lender or vendor such insurance at least thirty (30) days prior to expiration of the existing policy. If an insurance policy procured by the borrower or purchaser is subsequently substituted for that then in force, the lender or vendor may impose a reasonable service charge as determined by the director for the transaction, and payment of such charge by the agent or broker shall not be a violation of any other

provision of this code. No service charge shall be imposed for normal insurance changes made during the term of the policy.

(4) The director may adopt a uniform statewide schedule of permissive maximum charges for the substitution of policies authorized in subdivision (3) above.

History.

1961, ch. 330, § 290, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in the introductory paragraph was added by the compiler to conform to the statutory citation style.

§ 41-1313. Unfair discrimination — Life insurance, annuities, and disability insurance. — (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(3) No person shall discriminate on the basis of a genetic test or private genetic information, as those terms are defined in [section 39-8302, Idaho Code](#), in the issuance of coverage, or the fixing of rates, terms or conditions, for any policy or contract of disability insurance or any health benefit plan.

History.

1961, ch. 330, § 291, p. 645; am. 2006, ch. 293, § 2, p. 903.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 293, added subsection (3).

RESEARCH REFERENCES

ALR. — [Construction and Application of Statutes Prohibiting Genetic Discrimination in Workplace. 6 A.L.R.7th 2.](#)

§ 41-1314. Rebates — Illegal inducements. — (1) Except as otherwise expressly provided by law, no person shall knowingly make, permit to be made, or offer to make any contract of insurance, or of annuity, or agreement as to such contract, other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity or in connection therewith, any rebate of premiums payable on the contract, or of any producer's commission related thereto, or any special favor or advantage in the dividends or other benefits thereon, or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the contract; or directly or indirectly give, or sell, or purchase or offer or agree to give, sell, purchase, or allow as inducement to such insurance or annuity or in connection therewith, and whether or not specified or to be specified in the policy or contract, any agreement of any form or nature promising returns and profits, or any stocks, bonds, or other securities, or interest present or contingent therein or as measured thereby, of any insurer or other person, or any dividends or profits accrued or to accrue thereon; or offer, promise or give anything of value whatsoever not specified in the contract. Nor shall any insured, annuitant, or policyholder or employee thereof, or prospective insured, annuitant or policyholder, or employee thereof, knowingly accept or receive, directly or indirectly, any such prohibited contract, agreement, rebate, advantage, employment, or other inducement.

(2) Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed producers, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, the usual and ordinary dividends, savings, or unabsorbed premium deposits.

(3) Nothing in this section shall be construed as prohibiting a life insurer, disability insurer, property insurer or casualty insurer, or producers who are marketing life insurance, disability insurance, property insurance or casualty insurance, from providing to a policyholder or prospective policyholder of life, disability, property or casualty insurance, any prizes,

goods, wares, merchandise, articles or property of an aggregate value not to exceed two hundred dollars (\$200) in a calendar year.

(4) Extension of credit for the payment of premium beyond the customary premium payment period without charging and collecting interest at a reasonable rate per annum on the amount of credit so extended and for the duration of such credit is prohibited under this section.

History.

1961, ch. 330, § 292, p. 645; am. 1969, ch. 214, § 46, p. 625; am. 2006, ch. 212, § 1, p. 643; am. 2011, ch. 259, § 1, p. 704.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 212, added subsection (3) and redesignated former subsection (3) as subsection (4).

The 2011 amendment, by ch. 259, in subsection (1), substituted “producer’s commission” for “agent’s, solicitor’s, or broker’s commission”; in subsection (2), substituted “producers” for “agents, solicitors, or brokers”; and, in subsection (3), inserted “disability insurer,” “disability insurance,” and “disability” and substituted “aggregate value not to exceed two hundred dollars (\$200) in a calendar year” for “aggregate value of fifty dollars (\$50.00) or less.”

CASE NOTES

[Costs and attorney fees.](#)

[Not an illegal inducement.](#)

[Costs and Attorney Fees.](#)

The district court’s award of costs and attorney fees was in error where the Idaho state department of insurance’s action involved a reasonable, yet erroneous, interpretation of an ambiguous statute partially because no Idaho appellate cases had applied this section, and the department had only the statute to guide it. [Cox v. Department of Ins., 121 Idaho 143, 823 P.2d 177 \(Ct. App. 1991\).](#)

Not an Illegal Inducement.

Where the insurance policies had already been purchased, the insureds and insurance agent had reached what they thought was a final price on the amount of the prepayment, and that price had been paid by the insureds before insurance company notified them that the policies were not fully prepaid, the subsequent additional payment required by insurance company gave rise to a legitimate dispute; therefore, the payment by insurance agent made to insurance company on behalf of insureds was made in an effort to settle a disputed claim with the insureds and to avoid personal liability, not as an inducement to purchasing the policy, and did not violate the anti-rebate section. *Cox v. Department of Ins.*, 121 Idaho 143, 823 P.2d 177 (Ct. App. 1991).

RESEARCH REFERENCES

ALR. — Construction and effect of state statute forbidding unfair trade practice or competition by discriminatory allowance of rebates, commissions, discounts, or the like. 41 A.L.R.4th 675.

§ 41-1315. Exceptions to discrimination or rebate provision — Life or disability policies, and annuity contracts. — Nothing in sections 41-1313 and 41-1314[, Idaho Code,] shall be construed as including within the definition of discrimination or rebates or illegal inducements any of the following practices:

(1) In the case of any contract of life insurance or life annuity, paying bonuses to policy holders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policy holders.

(2) In the case of life insurance policies issued on the debit plan, making allowance to policy holders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(3) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(4) Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check or payroll deduction plan or other similar plan at a reduced rate reasonably related to the savings made by use of such plan.

(5) Issuance of life or disability insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, or modification of premium or rate based on amount of insurance; but any such issuance or modification shall not result in reduction in premium or rate in excess of savings in administration and issuance expenses reasonably attributable to such policies or contracts.

History.

1961, ch. 330, § 293, p. 645.

STATUTORY NOTES

Compiler's Notes.

As enacted the section heading of this section read: "Exceptions to discrimination, rebates provision — Life disability, and annuity contracts."

The bracketed insertion in the introductory paragraph was added by the compiler to conform to the statutory citation style.

§ 41-1315A. Discounts to employees. — No provision of title 41, Idaho Code, shall be deemed to prohibit allowance by an insurer, agent, or broker to the insurer's or licensee's bona fide full-time salaried employee of a discount from the premium otherwise payable for insurance on the employee's life or health or those of his dependents, or on the employee's property or risks other than property or risks used or involved in business operations of the employee other than as an employee of the insurer, agent, or broker. The amount of discount shall in no event exceed the amount of the agent's commission that the employer insurer may otherwise pay or the amount of commission to be received by the employer agent or broker, with respect to the insurance. Title insurers and title insurance agents may provide reimbursements or discounts of escrow fees or title insurance premiums in accordance with chapter 27, title 41, Idaho Code.

History.

I.C., § 41-1315A, as added by 1972, ch. 369, § 9, p. 1072; am. 2001, ch. 296, § 6, p. 1044; am. 2018, ch. 213, § 1, p. 481.

STATUTORY NOTES

Amendments.

The 2018 amendment, by ch. 213, added the last sentence in the section.

§ 41-1316. Stock operations and advisory board contracts. — No person shall issue or deliver or permit its agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or any advisory board contract or other contract of any kind promising returns and profits as an inducement to insurance.

History.

1961, ch. 330, § 294, p. 645.

§ 41-1317. Fictitious groups. — (1) No insurer, whether an authorized insurer or an unauthorized insurer, shall make available through any rating plan or form, property, casualty or surety insurance to any firm, corporation, or association of individuals, any preferred rate or premium based upon any fictitious grouping of such firm, corporation, or individuals. For the purposes of this section a “fictitious” group is one in which members of such group do not have a common insurable interest as to the subject of the insurance and the risk or risks insured or to be insured.

(2) No form or plan of insurance covering any group or combination of persons or risks shall be written or delivered within or outside of Idaho to cover Idaho persons or risks at any preferred rate or form other than that offered to persons not in such group and the public generally, unless such form, plan or policy and the rates or premiums to be charged therefor have been submitted to and approved by the director as not in conflict with subsection (1) above, and section 41-1405 (rate standards), Idaho Code.

(3) Nothing in this section shall apply to workmen’s [worker’s] compensation, life or disability insurance or to annuity contracts; nor to any insurer which restricts its insurance coverages to members of a particular association or organization with which the insurer is directly affiliated; nor to credit unemployment insurance indemnifying a creditor for installment or other periodic payments on indebtedness becoming due while a debtor has suffered loss of income resulting from involuntary unemployment; nor to municipal corporations, governmental employers or governmental entities; nor to group casualty or liability coverage when the director has determined that an affinity of interest legitimately exists between or among the members of the group.

History.

1961, ch. 330, § 295, p. 645; am. 1969, ch. 214, § 47, p. 625; am. 1972, ch. 360, § 1, p. 1065; am. 1977, ch. 241, § 1, p. 718; am. 1979, ch. 314, § 2, p. 846.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the beginning of subsection (3) was added by the compiler to reflect the current provisions of Title 72, Idaho Code.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1318. Interlocking ownership or management. — (1) Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this code, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.

(2) Any person otherwise qualified may be a director of two or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create a monopoly.

History.

1961, ch. 330, § 296, p. 645.

§ 41-1319. Desist orders for prohibited practices. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 297, p. 645, was repealed by S.L. 2005, ch. 78, § 3. For present comparable provisions, see § 41-213.

§ 41-1320. Service of notices and processes. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 298, p. 645, was repealed by S.L. 2005, ch. 77, § 7.

§ 41-1321. Procedures as to undefined practices. — [(1)] Whenever the director has reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not expressly prohibited or defined in this chapter, that such method of competition is unfair or that such act or practice is unfair or deceptive and that a proceeding by him in respect thereto would be to the interest of the public, he may issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon as provided for in chapter 2, title 41, Idaho Code, or seek any other relief authorized by title 41, Idaho Code.

History.

1961, ch. 330, § 299, p. 645; am. 2005, ch. 77, § 8, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The subsection designation (1) has been enclosed in brackets to reflect that it has become surplusage following the deletion of former subsections (2) through (4) by S.L. 2005, ch. 77, § 8.

§ 41-1322. Appeal by intervenor. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 300, p. 645, was repealed by S.L. 2005, ch. 77, § 9.

§ 41-1323. Illegal dealing in premiums — Excess charges for insurance. — (1) No person shall wilfully collect any sum as premium or charge for insurance, which insurance is not then provided or is not in due course to be provided (subject to acceptance of the risk by the insurer) by an insurance policy issued by an insurer as authorized by this code.

(2) No person shall wilfully collect as premium or charge for insurance any sum in excess of the premium or charge applicable to such insurance, and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the director; or, in cases where classifications, premiums, or rates are not required by this code to be so filed and approved, such premiums and charges shall not be in excess of those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus line brokers licensed under chapter 12[, title 41, Idaho Code] of this code, of the amount of applicable state and federal taxes in addition to the premium required by the insurer. Nor shall it be deemed to prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(3) Each violation of this section shall be punishable under section 41-117[, Idaho Code] (general penalty).

History.

1961, ch. 330, § 301, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in the second sentence in subsection (2) and in subsection (3) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Coverage.

An insurance policy was not illusory where the coverage simply limited coverage to employees while acting in their duties, and the driver would have been covered under the policy had he been acting within his duties, which he was not. *Nat'l Union Fire Ins. Co. v. Dixon*, 141 Idaho 537, 112 P.3d 825 (2005).

§ 41-1324. Report of exact consideration to insurer. — Every agent, broker or other insurance representative shall report to the insurer the exact consideration charged for any insurance policy or contract. If any policy, contract or certificate of insurance is issued by the agent, broker or representative, such exact consideration shall also be shown therein. This provision shall not apply as to certificates or other evidence of insurance issued to individuals as to coverage under group life or group disability insurance or group annuity contracts; nor as to any form of insurance contract lawfully authorized by the insurer and under which the amount of the premium is to be determined subsequent to the issuance of the contract.

History.

1961, ch. 330, § 302, p. 645.

RESEARCH REFERENCES

ALR. — Liability of agent or broker. 64 A.L.R.3d 398; 72 A.L.R.3d 704; 72 A.L.R.3d 735; 72 A.L.R.3d 747.

§ 41-1325. Borrowing money from clients. — (1) An insurance producer who borrows money, securities or anything of value from a client or customer, unless the client or customer is a person engaged in the business of loaning funds or is an immediate family member of the insurance producer, shall complete a written loan agreement that sets forth the parties to the loan, the purpose of the loan, the amount of the loan and the terms of the loan. All parties to the loan must sign the loan agreement acknowledging the transaction and must receive a copy of the loan agreement. The insurance producer shall keep a record of the loan transaction until the loan is paid back in full. Any release of the debt shall be in writing and signed by all parties to the release.

(2) As used in this section, the term “immediate family member” means a parent, mother-in-law, father-in-law, husband, wife, sister, brother, brother-in-law, sister-in-law, son-in-law, daughter-in-law, or a son or daughter.

History.

I.C., § 41-1325, as added by 2005, ch. 73, § 1, p. 250.

STATUTORY NOTES

Prior Laws.

Another former § 41-1325, which comprised 1961, ch. 330, § 303, p. 645, was repealed by S.L. 1981, ch. 23, § 2.

Compiler’s Notes.

Former § 41-1325, as added by S.L. 1981, ch. 23, § 3, was amended and redesignated as § 41-293 by § 5 of S.L. 1994, ch. 219.

§ 41-1326. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

Former § 41-1326 was amended and redesignated as § 41-294 by § 6 of S.L. 1994, ch. 219.

§ 41-1327. Violations — Penalty. — Any person who violates any provision of this chapter as to which a penalty is not expressly provided, or who violates a cease and desist order issued by the director under [section 41-213, Idaho Code](#), after such order has become final, shall be subject to penalties as prescribed by or referred to in [section 41-117, Idaho Code](#) (general penalty).

History.

1961, ch. 330, § 305, p. 645; am. 2005, ch. 78, § 4, p. 78.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1328. Payment of claims by insurers. — Every insurer issuing a motor vehicle insurance policy, as defined in chapter 5, title 41, Idaho Code, shall, in the event of damage to a covered motor vehicle by collision and the election by the insurer to have such motor vehicle repaired, make payment by check or draft, payable to the repairer or to the named insured and the repairer, jointly, no later than twenty (20) days subsequent to receipt of an itemized bill or invoice covering repairs authorized by the insurer which have been satisfactorily completed.

History.

I.C., § 41-1328, as added by 1974, ch. 159, § 1, p. 1393.

§ 41-1328A. Repair of motor vehicles. — The purpose of [sections 41-1328A through 41-1328D, Idaho Code](#), is to regulate the use of aftermarket crash parts by requiring disclosure by the repair facility when any use is proposed of an aftermarket, nonoriginal equipment manufacturer's crash part, and by requiring that the manufacturers of such aftermarket crash parts identify their products.

History.

[I.C., § 41-1328A](#), as added by 1990, ch. 156, § 1, p. 342.

§ 41-1328B. Definitions. — For the purposes of sections 41-1328A through 41-1328D, Idaho Code, the following definitions apply:

(1) “Aftermarket crash part” means a replacement part for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.

(2) “Installer” means an individual who actually does the work of replacing or repairing parts of a motor vehicle.

(3) “Insurer” means an insurance company and any person authorized to represent the insurer with respect to a claim.

(4) “Nonoriginal equipment manufacturer (non-OEM) aftermarket crash part” means a replacement part not made for or by the manufacturer of the motor vehicle.

(5) “Repair facility” means any motor vehicle dealer, garage, body shop or other commercial entity which undertakes the repair or replacement of those parts that generally constitute the exterior of a motor vehicle.

History.

I.C., § 41-1328B, as added by 1990, ch. 156, § 1, p. 342.

STATUTORY NOTES

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1328C. Identification of parts. — Any aftermarket crash part supplied by a nonoriginal equipment manufacturer for use in this state shall have affixed thereto or inscribed thereon the logo or name of its manufacturer. Such manufacturer's logo or name shall be visible after installation whenever practicable.

History.

I.C., § 41-1328C, as added by 1990, ch. 156, § 1, p. 342.

§ 41-1328D. Use of parts — Disclosure. — It shall be an unfair claim settlement practice for an insurer to specify the use of nonoriginal equipment manufacturer aftermarket crash parts in the repair of an insured's motor vehicle, or for a repair facility or installer to use non-OEM aftermarket crash parts to repair a vehicle, if the consumer has not been advised in writing. In all instances where non-OEM aftermarket crash parts are intended for use by an insurer:

(1) The written estimate shall clearly identify each such part intended for use, and

(2) A disclosure document containing the following information in ten (10) point or larger type shall appear on or be attached to the insured's copy of the estimate:

“This estimate has been prepared based on the use of crash parts supplied by a source other than the manufacturer of your motor vehicle. Warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle.”.

History.

I.C., § 41-1328D, as added by 1990, ch. 156, § 1, p. 342.

§ 41-1329. Unfair claim settlement practices. — Pursuant to [section 41-1302, Idaho Code](#), committing or performing any of the following acts or omissions intentionally, or with such frequency as to indicate a general business practice shall be deemed to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(10) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

History.

I.C., § 41-1329, as added by 1977, ch. 218, § 2, p. 654; am. 1987, ch. 278, § 12, p. 571.

CASE NOTES

Action in tort by insured.

Investigation of third party claims.

Private suits.

Action in Tort by Insured.

Under this section, an insured can state a tort action, distinct from an action on the contract, for an insurer's bad faith in handling the claims of an insured. *State Farm Fire & Cas. Co. v. Trumble*, 663 F. Supp. 317 (D. Idaho 1987).

Idaho law recognizes a tort cause of action against an insurer who negligently delays the settlement of an insurance claim. *Reynolds v. American Hdwe. Mut. Ins. Co.*, 115 Idaho 362, 766 P.2d 1243 (1988).

Even if Idaho courts would entertain actions by insureds for an insurer's bad faith in settling third party claims, that tort duty does not necessarily encompass a duty to investigate before suit is filed or a duty to initiate settlement negotiations before suit is filed. *Morrell Constr., Inc. v. Home Ins. Co.*, 920 F.2d 576 (9th Cir. 1990).

In a suit stemming from an insurer's bad faith breach of contract, the trial court did not err in instructing the jury on this chapter, because such instruction did not, as the insurer argued, change the chapter from potential evidence of the industry standard to the law governing bad faith claims. Nowhere in its jury instruction did the court imply that the statute created a private right of action. *Weinstein v. Prudential Prop. & Cas. Ins. Co.*, 149 Idaho 299, 233 P.3d 1221 (2010).

Investigation of Third Party Claims.

Where the insured wanted its insurer to investigate third party claims before a complaint was filed, it could have bargained for a different insurance policy, most likely with a higher premium but, instead, it purchased a policy which explicitly left investigations to the discretion of its insurer, the court declined to rewrite the parties' insurance policy via tort law to impose an obligation on an insurer to investigate a claim before a third party files suit. *Morrell Constr., Inc. v. Home Ins. Co.*, 920 F.2d 576 (9th Cir. 1990).

Private Suits.

Where district court previously dismissed plaintiffs' claim for bad faith based upon a determination that the cause of action did not exist, in light of the Idaho supreme court's decision in *White v. Unigard Mutual Insurance Co.*, 112 Idaho 94, 730 P.2d 1014 (1986) wherein such a cause of action was recognized, district court reinstated plaintiffs' claim for bad faith. *Idaho v. Bunker Hill Co.*, 662 F. Supp. 725 (D. Idaho 1987).

There is a common law duty on the part of insurers to their insureds to settle first party claims in good faith, and a breach of this duty will give rise to an action in tort, distinct from an action on the contract, but this section does not give rise to a private right of action whereby an insured can sue the insurer for statutory violations committed in connection with the settlement

of the insured's claim. *White v. Unigard Mut. Ins. Co.*, 112 Idaho 94, 730 P.2d 1014 (1986).

This section may furnish grounds for administrative action against an insurance company, or for the government to seek judicial relief from certain unfair practices, but it does not give rise to a private right of action whereby an insured can sue an insurer for statutory violations committed in connection with the settlement of the insured's claim. *Greene v. Truck Ins. Exch.*, 114 Idaho 63, 753 P.2d 274 (Ct. App. 1988), cert. denied, 116 Idaho 467, 776 P.2d 829 (1989).

RESEARCH REFERENCES

ALR. — What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: risks, causes, and extent of loss, injury, disability, or death. 123 A.L.R.5th 259.

§ 41-1329A. Unfair claims settlement practices — Penalty. — The director, if he finds after a hearing, that an insurer has violated the provisions of [section 41-1329, Idaho Code](#), may, in his discretion, impose an administrative penalty not to exceed ten thousand dollars (\$10,000) to be deposited by the director as provided in [section 41-406, Idaho Code](#), and may, in addition to the fine, or in the alternative to the fine, refuse to continue or suspend or revoke an insurer's certificate of authority.

History.

[I.C., § 41-1329A](#), as added by 1987, ch. 278, § 13, p. 571.

STATUTORY NOTES

Compiler's Notes.

Section 19 of S.L. 1987, ch. 278 read: "The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act."

Effective Dates.

Section 18 of S.L. 1987, ch. 278, as amended by § 1 of S.L. 1990, ch. 121, read: "The provisions of this act shall take effect on July 1, 1987, provided however, that Sections 1 through 11 shall apply only to causes of action which accrue on and after July 1, 1987."

§ 41-1330. Failure to maintain complaint handling procedures. — Every authorized insurer shall maintain a complete record of all the complaints which it has received since the date of its last examination under **section 41-219, Idaho Code**. This record shall indicate on a state by state basis, the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this section, “complaint” shall mean any written communication primarily expressing a grievance.

History.

I.C., § 41-1330, as added by 1977, ch. 218, § 3, p. 654.

§ 41-1331. Claims forms statement. — (1) All claims forms may contain a statement that clearly states in substance the following: “Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.” The lack of such a statement shall not constitute a defense against prosecution under this section.

(2) For the purposes of this section, “statement” includes, but is not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, x-ray test results, or other evidence of loss, injury, or expense.

History.

I.C., § 41-1331, as added by 1981, ch. 23, § 4, p. 39; am. 1982, ch. 178, § 1, p. 466.

§ 41-1332. Return of unearned premium for disability policies. —
Upon the death of a disability policyholder, the insurer shall immediately return any applicable unearned premium on a prorated basis for the period beginning with the month after the month of death for which there is no risk or loss to the company. Violation of the provisions of this section shall subject the insurer to an administrative penalty not to exceed five thousand dollars (\$5,000) for deposit in the general account [fund] of the state of Idaho. The provisions of this section shall not apply to credit disability insurance policies.

History.

I.C., § 41-1332, as added by 1989, ch. 140, § 1, p. 330.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in the second sentence was added by the compiler to correct the name of the referenced fund. See § 67-1205.

§ 41-1333. Refund of unearned health insurance premiums. — If an insured person, insured person's estate or entity cancels a health insurance policy for any reason, the insurer or other entity regulated pursuant to the provisions of this title shall refund the pro rata portion of the unused collected premium to the beginning of the next monthly billing cycle. As used in this section the term "health insurance policy" shall refer to a contract entered into pursuant to the provisions of this title for which payment or reimbursement is rendered to a claimant or health care provider for the claimant's utilization of health care services which is any service rendered to an individual for diagnosis, relief or treatment of any injury, ailment or bodily condition. As used in this section "unused collected premium" shall mean that portion of any premium collected which is not used, on a pro rata basis to the beginning of the next monthly billing cycle at the time of cancellation, by the insurer or other entity regulated pursuant to this title to insure against loss as there is no risk of loss from the insured individual, or that portion of any collected premium which would have not been collected had the insured paid monthly.

History.

I.C., § 41-1333, as added by 1993, ch. 339, § 1, p. 1271.

§ 41-1334. Disclosure of nonpublic personal information. — (1) No person required to be licensed or authorized pursuant to title 41, Idaho Code, shall disclose any nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley act of 1999, public law 106-102.

(2) The director may adopt rules necessary to carry out this section. The rules shall be consistent with the provisions of title V of the Gramm-Leach-Bliley act of 1999.

(3) Nothing in this section shall be construed to create a private cause of action.

History.

I.C., § 41-1334, as added by 2002, ch. 5, § 1, p. 5.

STATUTORY NOTES

Federal References.

Title V of the Gramm-Leach-Bliley Act, [Public Law 106-102](#), referred to in this section, is generally codified as [15 USCS § 6801 et seq.](#)

Effective Dates.

Section 2 of S.L. 2002, ch. 5 declared an emergency. Approved February 5, 2002.

§ 41-1335. Release of patient identifiable prescription information prohibited — Exceptions. — (1) No person shall release or sell, or include in any policy of insurance delivered or issued for delivery in this state any provision for the release or sale of any information pertaining to prescriptions, drug orders, records or any other prescription information that specifically identifies an individual insured, except as authorized under the provisions of [section 54-1727, Idaho Code](#).

(2) In addition to any other penalties provided by law, any person violating the provisions of this section shall be subject to an administrative penalty not to exceed three thousand dollars (\$3,000) for each violation.

(3) No person who releases records or information specified in subsection (1) of this section in good faith pursuant to the provisions of [section 54-1727, Idaho Code](#), shall be subject to penalty or liability, nor shall a cause of action exist against such person, for any loss or damage based upon the release of the records or information.

History.

[I.C., § 41-1335](#), as added by 2000, ch. 189, § 2, p. 465.

§ 41-1336. Requirements for compliance. — It shall be a violation of this chapter for an insurer to fail to comply with the requirements applicable to insurers under chapter 12, title 32, Idaho Code.

History.

I.C., § 41-1336, as added by 2003, ch. 304, § 12, p. 833.

STATUTORY NOTES

Compiler's Notes.

Both S.L. 2003, ch. 85, § 1, approved March 17, 2003, effective July 1, 2003 and S.L. 2003, ch. 304, § 12, approved April 21, 2003, effective July 1, 2003, purported to enact a new section of chapter 13, title 41 of the Idaho Code, designated as § 41-1336. Section 41-1336 as enacted by ch. 85, § 1 was compiled temporarily as § 41-1337 and the § 41-1336 as enacted by ch. 304, § 12 was compiled as § 41-1336. The section added by S.L. 2003, ch. 85, § 1 was permanently renumbered as § 41-1337 by S.L. 2004, ch. 318, § 11.

RESEARCH REFERENCES

ALR. — Purchase of annuity by debtor as fraud on creditors. 74 A.L.R.6th 549.

§ 41-1337. Life insurance — Payment of interest on benefits. — (1)

An insurer shall pay the proceeds of any benefits under a policy of life insurance not more than thirty (30) days after the insurer has received satisfactory proof of death of the insured. Except as provided in subsection (2) of this section, if the proceeds are not paid within the thirty (30) day period, the insurer shall also pay interest on the proceeds from the date of death of the insured to the date when the proceeds are paid.

(2) If satisfactory proof of death is received more than one hundred eighty (180) days after the death of the insured and the death benefits are not paid within thirty (30) days after satisfactory proof of death has been received by the insurer, interest shall accrue from the date on which satisfactory proof was received by the insurer to the date when proceeds are paid.

(3) The rate of interest to be paid by the insurer under subsections (1) and (2) of this section shall be the current rate of interest on death proceeds on deposit with the insurer; provided however, that if the insurer holds its deposits in a noninterest-bearing account or in an account bearing less than two percent (2%) interest per annum, the rate of interest to be paid shall be the one (1) month United States government securities treasury constant maturity rate as disclosed in the federal reserve statistical release publication H.15, selected interest rates, as of the first of the month preceding the date of death, plus two (2) percentage points.

(4) A payment of interest shall not be required under this section in any case in which the beneficiary elects to receive the proceeds under the policy by any means other than a lump sum payment.

History.

I.C., § 41-1336, as added by 2003, ch. 85, § 1, p. 260; am. and redesign. 2004, ch. 318, § 11, p. 892.

STATUTORY NOTES

Compiler's Notes.

Both S.L. 2003, ch. 85, § 1, approved March 17, 2003, effective July 1, 2003 and S.L. 2003, ch. 304, § 12, approved April 21, 2003, effective July 1, 2003, purported to enact a new section of chapter 13, title 41 of the Idaho Code, designated as § 41-1336. Section 41-1336 as enacted by ch. 85, § 1 was compiled temporarily as § 41-1337 and the § 41-1336 as enacted by ch. 304, § 12 was compiled as § 41-1336. The section as added by S.L. 2003, ch. 85, § 1 was permanently renumbered as § 41-1337 by S.L. 2004, ch. 318, § 11.

For the selected interest rates in federal reserve statistical release H.15, see <http://www.federalreserve.gov/releases/H15/current>.

Effective Dates.

Section 14 of S.L. 2004, ch. 318 declared an emergency retroactively to January 1, 2004. Approved March 24, 2004.

§ 41-1338. Uninsured vehicle tracking — Penalties. — Tracking uninsured vehicles through online insurance verification is an important policy of the state of Idaho that requires the participation of all auto insurers. Failure to comply with the provisions of [section 49-1234, Idaho Code](#), shall constitute a wrongful practice and the insurer shall be subject to penalties pursuant to [section 41-327, Idaho Code](#).

History.

[I.C., § 41-1338](#), as added by 2016, ch. 141, § 2, p. 407.

Chapter 14

PROPERTY INSURANCE RATES

Sec.

41-1401. Scope of chapter.

41-1402. Purpose of law — Interpretation.

41-1403 41-1404. Insurer's election where two laws apply — Rate-making factors. [Repealed.]

41-1405. Rate standards.

41-1406 — 41-1414. Rate filings required — Exemptions — Effective date — Disapproval — Excess rates — Deviations — Submission to examining bureau. [Repealed.]

41-1415. Rating organizations — Licensing.

41-1416. Period license effective — Renewal — Fee — Suspension or revocation.

41-1417. Admission of subscribers — Services nondiscriminatory.

41-1418, 41-1419. Expenses of property insurance rating organization — Rules not to affect dividends. [Repealed.]

41-1420. Notice of rating organization changes.

41-1421. Technical services.

41-1422 — 41-1424. Appeal by minority — Information to insureds — Appeal from filing. [Repealed.]

41-1425. Advisory organizations.

41-1426. Joint underwriting or joint reinsurance.

41-1427. Examination of insurers and rating, advisory, joint underwriting, and joint reinsurance organizations.

41-1428. Recording and reporting of loss and expense experience.

41-1429. Interchange of data — Consultation.

41-1430. Disclosure of information and immunity.

41-1431. False or misleading information.

41-1432. Penalties for violations or noncompliance.

41-1433. Rules and regulations.

41-1434. Hearing procedure.

41-1435. Appeal from the director. [Repealed.]

41-1436. Definitions.

41-1437. Making and use of rates.

41-1438. Two or more insurers may act in concert.

41-1439. Records.

41-1440. Hearings.

41-1441. Assigned risks.

§ 41-1401. Scope of chapter. — (1) Except as provided in section 41-1619[, Idaho Code] (other provisions applicable, workmen's [worker's] compensation rates), and except as provided in subsection (3) below, this chapter applies to property, marine and transportation, inland marine, casualty (other than workmen's [worker's] compensation coverages) and surety (other than the insurance or guaranty of the obligations of employers under workmen's [worker's] compensation laws) insurances, as such property, marine and transportation, casualty and surety insurances are defined in chapter 5, title 41, Idaho Code, on risks located or operations to be performed in this state.

(2) "Inland marine" insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the director, or as established by general custom of the business, as inland marine insurance.

(3) This chapter shall further not apply as to:

(a) Reinsurance, other than joint reinsurance to the extent stated in section 41-1426[, Idaho Code];

(b) Insurance of vessels or craft, their cargos, marine builders' risks, marine protection and indemnity; or other risks commonly insured under marine, as distinguished from inland marine, insurance policies;

(c) Insurance against loss of or damage to aircraft or against liability arising out of ownership, maintenance or use of aircraft, nor to insurance of hulls of aircraft, including their accessories and equipment;

(d) Any domestic self-insurer for fire; or

(e) Any reciprocal insurer writing hazards or perils for its members exclusively associated with a single industry.

History.

1961, ch. 330, § 306, p. 645; am. 1969, ch. 306, § 1, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions of “[worker’s]” in subsection (1) were added by the compiler to reflect the current provisions of Title 72, Idaho Code.

The bracketed insertions of “[, Idaho Code,]” near the beginning of subsection (1) and in paragraph (3)(a) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1402. Purpose of law — Interpretation. — (1) The purpose of this chapter is to promote the public welfare by regulating insurance rates as herein provided to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of this chapter.

(2) It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis, and nothing in this chapter is intended to give the director power to fix and determine a rate level by classification or otherwise.

(3) This chapter shall be liberally interpreted to carry into effect the provisions of this section.

History.

1961, ch. 330, § 307, p. 645; am. 1969, ch. 306, § 2, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1403, 41-1404. Insurer's election where two laws apply — Rate-making factors. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised S.L. 1961, ch. 330, §§ 308, 309, were repealed by S.L. 1969, ch. 306, § 26.

§ 41-1405. Rate standards. — (1) Rates shall not be excessive, inadequate or unfairly discriminatory.

(2) No rate shall be held to be excessive unless the director finds that: (a) Such rate is unreasonably high for the insurance provided, and (b) A reasonable degree of competition does not exist in Idaho with respect to the classification to which the rate is applicable.

(3) No rate shall be held to be inadequate unless the director finds that: (a) Such rate is unreasonably low for the insurance provided and the continued use of such rate endangers the solvency of the insurer using the same, or (b) Such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using the same has, or if continued will have, the effect of destroying competition or creating a monopoly.

(4) Neither of such findings shall be made by the director except after a hearing on reasonable notice.

(5) Nothing contained in this chapter shall be construed to repeal or modify the provisions of chapter 13, title 41 (trade practices and frauds), Idaho Code, and any rate, rating classification, rating plan or schedule, or variation thereof, established in violation of any of such provisions shall, in addition to the consequences stated in such chapter or elsewhere, be deemed a violation of this section.

History.

1961, ch. 330, § 310, p. 645; am. 1969, ch. 306, § 3, p. 917; am. 1977, ch. 142, § 6, p. 303.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Cited Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976).

§ 41-1406 — 41-1414. Rate filings required — Exemptions — Effective date — Disapproval — Excess rates — Deviations — Submission to examining bureau. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, comprising S.L. 1961, ch. 330, §§ 311 to 319, p. 645, were repealed by S.L. 1969, ch. 306, § 26.

§ 41-1415. Rating organizations — Licensing. — (1) Any person, corporation, unincorporated association, partnership or individual, whether located within or outside this state, not an officer or employee of any insurer, may apply to the director for a license as a rate making organization for such kinds of insurance or subdivisions or classes of risk or part or combination thereof as are specified in its application. Any property insurance rating bureau licensed under the provisions of this chapter, except a crop hail or nuclear energy insurance rating bureau, shall be entirely independent in its operation and management and shall not be a branch or division of any other property insurance rating bureau. A property insurance rating organization shall establish and maintain a rate making office in this state, and to the extent reasonably possible shall maintain in such office all the files and records relating to the rates currently made by such rating organization and the making thereof; but this provision does not apply as to marine or inland marine or crop hail insurance rating organizations.

(2) As part of its application the rating organization shall file with the director:

- (a) Copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its by-laws, rules and regulations governing the conduct of its business;
- (b) A list of its members and subscribers;
- (c) The name and address of a resident of this state upon whom notices or orders of the director or process affecting the rating organization may be served; and
- (d) A statement of its qualifications as a rating organization.

(3) If the director finds that the applicant is competent, trustworthy and otherwise qualified to act as a rating organization, and that its constitution, articles of agreement or association or certificate of incorporation, and its by-laws, rules and regulations governing the conduct of its business conform to the requirements of law, he shall issue a license specifying the kinds of insurance or subdivision or class of risk or part or combination thereof for which the applicant is authorized to act as a rating organization.

Every such application shall be granted or denied in whole or in part by the director within sixty (60) days of the date of its filing with him.

History.

1961, ch. 330, § 320, p. 645; am. 1966 (2nd E.S.), ch. 2, § 1, p. 12; am. 1969, ch. 306, § 4, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 2 of S.L. 1966 (2nd E.S.), ch. 2 declared an emergency. Approved March 10, 1966.

§ 41-1416. Period license effective — Renewal — Fee — Suspension or revocation. — (1) Licenses issued to rating organizations under [section 41-1415, Idaho Code](#), shall remain in effect for one (1) year, unless sooner suspended or revoked by the director, and may be renewed for successive periods of one (1) year each upon application of the rating organization and payment in advance of the license fee.

(2) The fee for the license shall be in the amount set forth by rule pursuant to [section 41-401, Idaho Code](#).

(3) The director may suspend or revoke the license if he finds, after a hearing thereon of which notice was duly given to the rating organization, that the rating organization no longer meets the requirements of [section 41-1415, Idaho Code](#), or for failure to comply with the director's order as provided in [section 41-1432, Idaho Code](#).

History.

1961, ch. 330, § 321, p. 645; am. 2001, ch. 85, § 5, p. 211.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1417. Admission of subscribers — Services nondiscriminatory.

— (1) Subject to rules which have been approved by the director as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance or subdivision thereof, or class of risk or a part or combination thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules shall be given to subscribers.

(2) Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

(3) The reasonableness of any rule in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the director at a hearing upon notice to the rating organization and to the subscriber or insurer in accordance with chapter 2, title 41, Idaho Code. If the director finds that such rule is unreasonable in its application to subscribers, he shall order that the rule shall not be applicable to subscribers. If a rating organization fails to grant or reject an insurer's application for subscribership within thirty (30) days after it was made, the insurer may request a review by the director as if the application had been rejected. If the director finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization was justified, he shall make an order affirming its action.

History.

1961, ch. 330, § 322, p. 645; am. 2005, ch. 77, § 10, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1418, 41-1419. Expenses of property insurance rating organization — Rules not to affect dividends. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised S.L. 1961, ch. 330, §§ 323, 324, were repealed by S.L. 1969, ch. 306, § 26.

§ 41-1420. Notice of rating organization changes. — Every rating organization shall notify the director promptly of every change in (1) its constitution, its articles of agreement or association, or its certificate of incorporation, and its by-laws, rules and regulations governing the conduct of its business, (2) its list of members and subscribers, and (3) the name and address of the resident of this state designated by it upon whom notice or orders of the director or process affecting such rating organization may be served.

History.

1961, ch. 330, § 325, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1421. Technical services. — Any rating organization may subscribe for or purchase actuarial, technical or other services, and such services shall be available to all members and subscribers without discrimination.

History.

1961, ch. 330, § 326, p. 645.

§ 41-1422 — 41-1424. Appeal by minority — Information to insureds — Appeal from filing. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised S.L. 1961, ch. 330, §§ 327 to 329, were repealed by S.L. 1969, ch. 306, § 26.

§ 41-1425. Advisory organizations. — (1) No advisory organization shall conduct its operations in this state unless and until it has filed with the director:

(a) A copy of its constitution, its articles of agreement or association, or its certificate of incorporation and of its by-laws, rules and regulations governing its activities; (b) A list of its members and subscribers; (c) The name and address of a resident of this state upon whom notices or orders of the director or process issued at his direction may be served; and (d) An agreement that the director may examine such advisory organization in accordance with the provisions of section 41-1427[, Idaho Code].

(2) Every such advisory organization shall notify the director promptly of every change in its constitution, its articles of certificate of incorporation, or of agreement or association, and of its by-laws, rules and regulations governing conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the director or process affecting such organization may be served.

(3) No such advisory organization shall engage in any unfair or unreasonable practice with respect to such activities.

History.

1961, ch. 330, § 330, p. 645; am. 1969, ch. 306, § 5, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of paragraph (1)(d) was added by the compiler to conform to the statutory citation style.

§ 41-1426. Joint underwriting or joint reinsurance. — (1) Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance, shall be subject to regulation with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other applicable provisions of this chapter, or chapter 16 (worker's compensation rates), title 41, Idaho Code, and, with respect to joint reinsurance to sections as follows:

(a) Section 41-1427[, Idaho Code] (examination of rating, advisory, and joint reinsurance organizations); (b) Section 41-1432[, Idaho Code] (penalties); and (c) Section 41-1434[, Idaho Code] (hearing procedure).

(2) If, after a hearing, the director finds that any activity or practice of any such group, association or other organization is unfair or unreasonable or otherwise inconsistent with the applicable provisions of this chapter, or chapter 16, title 41, Idaho Code, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with such provisions, and requiring the discontinuance of such activity or practice.

History.

1961, ch. 330, § 331, p. 645; am. 1969, ch. 306, § 6, p. 917; am. 2005, ch. 77, § 11, p. 258.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in paragraphs (1)(a), (1)(b), and (1)(c) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1427. Examination of insurers and rating, advisory, joint underwriting, and joint reinsurance organizations. — (1) As often as he deems necessary, and not less frequently than each five (5) years, the director shall examine each licensed rating organization, each advisory organization, each group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, and each authorized insurer transacting in this state any class of insurance to which the provisions of this chapter are applicable. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of this chapter. As to insurers, no such examination requirement shall be satisfied by the periodic examination of the insurer's general affairs.

(2) In lieu of any such examination the director may accept the report of a similar examination made by the insurance supervisory official of another state.

(3) The reasonable cost of the examination shall be paid by the person examined, and such person shall be subject, as though an “insurer,” to the provisions of [section 41-228, Idaho Code](#), (examination expense).

(4) Such examination shall also be subject to the applicable provisions of [sections 41-223, Idaho Code](#), (conduct of examination), 41-227, Idaho Code, (examination report), 41-229, Idaho Code, (witnesses and evidence) and 41-230, Idaho Code, (testimony compelled — immunity from prosecution).

History.

1961, ch. 330, § 332, p. 645; am. 1969, ch. 306, § 7, p. 917; am. 2007, ch. 279, § 1, p. 810.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 279, substituted “five (5) years” for “three (3) years” in subsection (1).

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1428. Recording and reporting of loss and expense experience.

— (1) The director shall promulgate and may modify reasonable rules and statistical plans, reasonably adapted to each of the rating systems used, [to time] and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rates comply with the applicable standards of this chapter. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience.

(2) In promulgating such rules and plans the director shall give due consideration to the rating systems in use in this state and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states.

(3) No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it.

(4) The director may designate one or more rating organizations or other agencies to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the director, to insurers and rating organizations.

History.

1961, ch. 330, § 333, p. 645; am. 1969, ch. 306, § 8, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words “to time” in the first sentence in subsection (1) were enclosed in brackets by the compiler, as they were inadvertently left in the section following the 1969 amendment.

§ 41-1429. Interchange of data — Consultation. — (1) The director may promulgate reasonable rules and plans for the interchange of data necessary for the application of rating plans.

(2) In order to further uniform administration of rate regulatory laws, the director and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

History.

1961, ch. 330, § 334, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1430. Disclosure of information and immunity. — (1) Information acquired as a result of any inspection or survey by any rating organization or advisory organization shall be disclosed, upon request, to any requesting person with an insurable interest in the property and to any person designated by regulation of the Idaho department of insurance. The rating organization or advisory organization may require the person requesting the information to pay the reasonable costs of duplicating the information requested.

(2) No rating organization, advisory organization, or its officers, directors, employees, or any of its members, shall be civilly liable for the information contained in any of its records or reports prepared in good faith and in accordance with this chapter. No rating organization, advisory organization, or its officers, directors or employees or any of its members shall have a duty to disclose the information contained in their records or reports except as provided in this chapter.

History.

I.C., § 41-1430, as added by 1982, ch. 347, § 1, p. 862.

STATUTORY NOTES

Compiler's Notes.

Former § 41-1430, which comprised S.L. 1961, ch. 330, § 335, was repealed by S.L. 1969, ch. 306, § 26.

§ 41-1431. False or misleading information. — No person or organization shall wilfully withhold information from, or knowingly give false or misleading information to, the director, any statistical agency designated by the director, any rating organization, or any insurer, which will affect the rates or premiums chargeable under this code. A violation of this section shall subject the one guilty of such violation to the penalties provided in section 41-1432[, Idaho Code].

History.

1961, ch. 330, § 336, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of the section was added by the compiler to conform to the statutory citation style.

§ 41-1432. Penalties for violations or noncompliance. — (1) Violations of this chapter, or of chapter 16 (worker's compensation rates), title 41, Idaho Code, shall be subject to the penalties provided by section 41-117 (general penalty), Idaho Code.

(2) After a hearing in accordance with chapter 2, title 41, Idaho Code, the director may suspend or revoke any insurer which has failed to comply with an order of the director within the time limited by the order, or within any extension of time which the director may grant. The director shall not so suspend or revoke for failure to comply with his order until the time prescribed for an appeal from such order has expired or if an appeal has been taken, until such order has been affirmed. The director may determine when the suspension or revocation shall become effective, and, subject to [section 41-329, Idaho Code](#), as to an insurer's certificate of authority, any suspension order shall remain in effect for the period fixed by him unless he modifies or rescinds the suspension or until the order upon which the suspension is based is modified, rescinded or reversed.

History.

1961, ch. 330, § 337, p. 645; am. 1969, ch. 306, § 9, p. 917; am. 2005, ch. 77, § 12, p. 258.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1433. Rules and regulations. — As provided in section 41-211[, Idaho Code] (rules and regulations) the director may make reasonable rules and regulations necessary to effectuate any provisions of this chapter or of chapter 16[, title 41, Idaho Code] (workmen's [worker's] compensation rates).

History.

1961, ch. 330, § 338, p. 645; am. 1969, ch. 306, § 10, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions of “[, Idaho Code]” and “[, title 41, Idaho Code]” were added by the compiler to conform to the statutory citation style.

The bracketed insertion of “[worker's]” near the end of the section was added by the compiler to reflect the current provisions of Title 72, Idaho Code.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1434. Hearing procedure. — [(1)] An insurer, rating organization, or insurance examining bureau aggrieved by an order or decision of the director made without a hearing, may, within thirty (30) days after notice of the order to the insurer, organization or bureau, make written request to the director for a hearing thereon. The director shall hear such party or parties in accordance with chapter 2, title 41, Idaho Code.

History.

1961, ch. 330, § 339, p. 645; am. 1969, ch. 306, § 11, p. 917; am. 2005, ch. 77, § 13, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The subsection designation (1) has been enclosed in brackets to reflect that it has become surplusage following the deletion of former subsections (2) through (4) by S.L. 2005, ch. 77, § 13.

§ 41-1435. Appeal from the director. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-1440, as added by 1969, ch. 306, § 17, p. 917; am. 1990, ch. 213, § 57, p. 480, was repealed by S.L. 2005, ch. 77, § 14.

§ 41-1436. Definitions. — As used in this chapter:

(1) “Rating organization” means every person, other than an authorized insurer, whether located within or outside this state, who has as his object or purpose the making of rates, rating plans or rating systems. Two (2) or more authorized insurers which act in concert for the purpose of making rates, rating plans or rating systems, and which do not operate within the specific authorizations contained in section 41-1426[, Idaho Code] (joint underwriting or joint reinsurance), section 41-1438[, Idaho Code] of this act (acts in concert), and section 41-1441[, Idaho Code] of this act (assigned risks), shall be deemed to be a rating organization.

(2) “Advisory organization” means every group, association, or other organization of insurers, whether located within or outside this state, which prepares policy forms or makes underwriting rules incident to but not including the making of rates, rating plans or rating systems or which collects and furnishes to authorized insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate-making, capacity.

(3) “Member” means an insurer which participates in or is entitled to participate in the management of a rating, advisory or other organization.

(4) “Subscriber” means an insurer which is furnished at its request:

(a) With rates and rating manuals by a rating organization of which it is not a member, or

(b) With advisory services by an advisory organization of which it is not a member.

(5) “Wilful” or “wilfully” in relation to an act or omission which constitutes a violation of this chapter means with actual knowledge or belief that such act or omission constitutes such violation and with specific intent nevertheless to commit such act or omission.

History.

I.C., § 41-1436, as added by 1969, ch. 306, § 13, p. 917.

STATUTORY NOTES

Compiler's Notes.

The three bracketed insertions in subsection (1) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1437. Making and use of rates. — (1) As to all rates which are subject to this chapter, due consideration shall be given to past and prospective loss experience within and outside this state, to the conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specifically applicable to this state, and to all other relevant factors, including judgment factors, within and outside this state; and in the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five (5) year period for which such experience is available.

(2) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(3) Risks may be grouped by classification for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions.

History.

I.C., § 41-1437, as added by 1969, ch. 306, § 14, p. 917.

§ 41-1438. Two or more insurers may act in concert. — (1) Subject to and in compliance with the provisions of this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two (2) or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research.

(2) With respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research, two (2) or more authorized insurers having a common ownership or operating in the state under common management or control, are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer, and to the extent that such matters relate to co-surety bonds, two (2) or more authorized insurers executing such bond are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer.

(3) Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules or policy or bond forms of such organizations, either consistently or intermittently, but except as provided in subsection (2) of this section, section 41-1426[, Idaho Code] (joint underwriting or joint reinsurance), and section 41-1441[, Idaho Code] (assigned risks) of this act, shall not agree with each other or rating organizations or others to adhere thereto. The fact that two (2) or more authorized insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization, or the underwriting rules or policy or bond forms prepared by a rating or advisory organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and may be used only for the purpose of

supplementing or explaining direct evidence of the existence of any such agreement.

(4) Licensed rating organizations and authorized insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to rate making and the application of rating systems.

(5) Upon compliance with the provisions of this chapter applicable thereto any rating organization, advisory organization, and any group, association or other organization of authorized insurers which engages in joint underwriting or joint reinsurance through such organization or by standing agreement among the members thereof, may conduct operations in this state. As respects insurance risks or operations in this state, no insurer shall be a member or subscriber of any such organization, group or association that has not complied with the provisions of this chapter applicable to it.

History.

I.C., § 41-1438, as added by 1969, ch. 306, § 15, p. 917.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in the first sentence in subsection (3) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1439. Records. — (1) Every insurer, rating organization or advisory organization and every group, association or other organization of insurers which engages in joint underwriting or joint reinsurance shall maintain reasonable records, of the type and kind reasonably adapted to its method of operation, of its experience or the experience of its members and of the data, statistics or information collected or used by it in connection with the rates, rating plans, rating systems, underwriting rules, policy or bond forms, surveys or inspections made or used by it, so that such records will be available at all reasonable times to enable the director to determine whether such organization, insurer, group or association, and, in the case of an insurer or rating organization, every rate, rating plan and rating system made or used by it, complies with the provisions of this chapter applicable to it. The maintenance of such records in the office of a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this section for any such insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating plans, rating systems or underwriting rules of such organization. Such records shall be maintained in an office within this state or shall be made available for examination or inspection within this state by the director at any time upon reasonable notice.

(2) In addition to or in lieu of any other penalty therefor, for each failure to maintain the records as required hereunder the director may impose upon the person so failing the penalty prescribed by section 41-1432[, Idaho Code].

History.

I.C., § 41-1439, as added by 1969, ch. 306, § 16, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of subsection (2) was added by the compiler to conform to the statutory citation style.

§ 41-1440. Hearings. — (1) Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may himself or by his authorized representative make written request of the insurer or rating organization to review the manner in which the rate, plan, system, or rule has been applied with respect to insurance afforded him. If the request is not granted within thirty (30) days after it is made, the requestor may treat it as rejected. Any person aggrieved by the refusal of an insurer or rating organization to grant the review requested, or by the failure or refusal to grant all or part of the relief requested, may file a written complaint and request for hearing with the director, specifying the grounds relied upon. If the director has already disposed of the issue as raised by a similar complaint, he may deny the hearing. If the director believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, he shall deny the hearing. Otherwise, and if he also finds that the complaint charges a violation of this chapter and that the complainant would be aggrieved if the violation is proven, he shall proceed as provided in subsection (2) of this section.

(2) If after examination of an insurer, rating organization, advisory organization, or group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, or upon the basis of other information, or upon sufficient complaint as provided in subsection (1) of this section, the director has good cause to believe that such insurer, organization, group or association, or any rate, rating plan or rating system made or used by any such insurer or rating organization, does not comply with the requirements and standards of this chapter applicable to it, he shall, unless he has good cause to believe such noncompliance is willful, give notice in writing to such insurer, organization, group or association stating therein in what manner and to what extent noncompliance is alleged to exist and specifying therein a reasonable time, not less than ten (10) days thereafter, in which the noncompliance may be corrected. Notices under this section shall be subject to disclosure according to chapter 1, title 74, Idaho Code, unless a hearing is held under subsection (3) of this section.

(3) If the director has good cause to believe that such noncompliance is willful, or if within the period prescribed by the director in the notice required by subsection (2) of this section, the insurer, organization, group or association does not make such changes as may be necessary to correct the noncompliance specified by the director or establish to the satisfaction of the director that such specified noncompliance does not exist, then the director may hold a public hearing in connection therewith in accordance with chapter 2, title 41, Idaho Code. If no notice has been given as provided in subsection (2) of this section, the notice shall state in what manner and to what extent noncompliance is alleged to exist. The hearing shall not consider any subject not specified in the notice required by subsection (2) of this section.

(4) If after a hearing pursuant to subsection (3) of this section, the director finds:

(a) That any rate, rating plan or rating system violates the applicable provisions of this chapter, he may issue an order to the insurer, or rating organization, group or association which has been the subject of the hearing specifying in what respects such violation exists and requiring compliance within a reasonable time thereafter.

(b) That an insurer, rating organization, advisory organization, or a group, association or other organization of insurers which engages in joint underwriting or joint reinsurance, is in violation of the applicable provisions of this chapter other than the provisions dealing with rates, rating plans or rating systems, he may issue an order to such insurer, organization, group or association which has been the subject of the hearing specifying in what respects such violation exists and requiring compliance within a reasonable time thereafter.

(c) That any such violation by an insurer or rating organization which has been the subject of hearing was willful, he may suspend or revoke, in whole or in part, the certificate of authority of such insurer or the license of such rating organization with respect to the class of insurance which has been a subject of the hearing.

(d) That any rating organization has willfully engaged in any fraudulent or dishonest act or practice, he may suspend or revoke, in whole or in

part, the license of such organization in addition to any other penalty provided in this chapter.

(5) Except as otherwise provided in this chapter, all proceedings in connection with the denial, suspension or revocation of a license or certificate of authority shall be conducted in accordance with the provisions of chapters 2 and 3, title 41, Idaho Code, and the director shall have all the powers granted to him therein.

History.

I.C., § 41-1440, as added by 1969, ch. 306, § 17, p. 917; am. 1990, ch. 213, § 57, p. 480; am. 2005, ch. 77, § 15, p. 258; am. 2015, ch. 141, § 110, p. 379.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in the last sentence of subsection (2).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 111 of S.L. 1990, ch. 213 as amended by § 16 of S.L. 1991, ch. 329 provided that §§ 3 through 45 and 48 through 110 of the act should take effect July 1, 1993.

§ 41-1441. Assigned risks. — Agreements may be made among casualty insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate codifications to be subject to the approval of the director. Premium charges for the assigned risk plan shall not be excessive, inadequate, nor unfairly discriminatory and shall provide sufficient revenue to make the plan self-sustaining and self-supporting.

History.

I.C., § 41-1441, as added by 1969, ch. 306, § 18, p. 917; am. 1996, ch. 305, § 2, p. 1000.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Chapter 15

MANAGING GENERAL AGENTS ACT

Sec.

41-1501. Short title.

41-1502. Definitions.

41-1503. Licensure.

41-1504. Required contract provisions.

41-1505. Duties of insurers.

41-1506. Examination authority.

41-1507. Penalties and liabilities.

§ 41-1501. Short title. — This chapter will be known and may be cited as the “Managing General Agents Act.”

History.

I.C., § 41-1501, as added by 1991, ch. 293, § 1, p. 754.

STATUTORY NOTES

Prior Laws.

Former §§ 41-1501 — 41-1521, which comprised S.L. 1961, ch. 330, §§ 341-361, were repealed by S.L. 1969, ch. 306, § 26.

§ 41-1502. Definitions. — For the purposes of this chapter:

(1) “Actuary” means a person who is a member in good standing of the American academy of actuaries.

(2) “Insurer” means any person, firm, association or corporation duly licensed in this state as an insurance company pursuant to and acting consistent with the definitions provided in sections 41-103 and 41-112, Idaho Code.

(3) “Managing general agent” (MGA) means any person, firm, association or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office) and acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five per cent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one (1) quarter or year together with one (1) or more of the following:

(a) Adjusts or pays claims in excess of an amount determined by the director, or

(b) Negotiates reinsurance on behalf of the insurer.

(4) Notwithstanding the above definition of MGA, the following persons shall not be considered as MGAs for the purposes of this chapter:

(a) An employee of the insurer;

(b) An United States manager of the United States branch of an alien insurer;

(c) An underwriting manager which, pursuant to contract, manages the insurance operations of the insurer, is under common control with the insurer, subject to the holding company [system] regulatory act, and whose compensation is not based on the volume of premiums written;

(d) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

(5) “Underwrite” means the authority to accept or reject risks on behalf of the insurer.

History.

I.C., § 41-1502, as added by 1991, ch. 293, § 1, p. 754.

STATUTORY NOTES

Prior Laws.

Former § 41-1502 was repealed. See Prior Laws, § 41-1501.

Compiler’s Notes.

For more on the American academy of actuaries, referred to in subsection (1), see <http://www.actuary.org>.

The bracketed insertion in paragraph (4)(c) was added by the compiler. The insurance holding company system regulatory act is a model law created by the national association of insurance commissioners, adopted as chapter 38, title 41, Idaho Code, in 2013. See <http://naic.org/>.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1503. Licensure. — (1) No person, firm, association or corporation shall act in the capacity of a MGA with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed agent in this state pursuant to the provisions of chapter 10, title 41, Idaho Code.

(2) No person, firm, association or corporation shall act in the capacity of a MGA representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as an agent in this state pursuant to the provisions of chapter 10, title 41, Idaho Code.

(3) Every MGA as defined in [section 41-1502\(3\), Idaho Code](#), shall be required to be bonded. The bond shall be in favor of the state to be held in trust for the benefit and protection of insureds and insurers whose money the MGA handles. The amount of the bond shall not be less than ten per cent (10%) of the amount of total funds handled, except that in no case shall such bond be less than five thousand dollars (\$5,000). For purposes of fixing the amount of such bond, the amount of funds handled shall be determined by the total funds handled by the MGA in the preceding year, or if no funds were handled during the preceding year, the amount of funds reasonably estimated to be handled during the current calendar year by the MGA. Only one (1) such bond shall be required of the MGA for all insurers which utilize the services of the MGA, unless provided otherwise in the written agreement between the insurer and the MGA or otherwise required by the director.

(4) The director may require the MGA to maintain an errors and omissions policy.

History.

[I.C., § 41-1503](#), as added by 1991, ch. 293, § 1, p. 754.

STATUTORY NOTES

Prior Laws.

Former § 41-1503 was repealed. See Prior Laws, § 41-1501.

§ 41-1504. Required contract provisions. — No person, firm, association or corporation acting in the capacity of a MGA shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities, and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination.

(2) The MGA will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) All funds collected for the account of an insurer will be held by the MGA in a fiduciary capacity in a bank which is a member of the federal reserve system. This account shall be used for all payments on behalf of the insurer. The MGA may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the MGA will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer and the director shall have access to all books, bank accounts and records of the MGA in a form usable to the director. Such records shall be retained for a minimum period of six (6) years.

(5) The contract may not be assigned in whole or part by the MGA.

(6) Appropriate underwriting guidelines including: (a) The maximum annual premium volume;

(b) The basis of the rates to be charged;

(c) The types of risks which may be written; (d) Maximum limits of liability;

- (e) Applicable exclusions;
- (f) Territorial limitations;
- (g) Policy cancellation provisions; and
- (h) The maximum policy period.

Any cancellation or nonrenewal of any policy of insurance is subject to all applicable laws and regulations concerning the cancellation and nonrenewal of insurance policies.

(7) If the contract permits the MGA to settle claims on behalf of the insurer: (a) All claims must be reported to the company in a timely manner.

(b) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim: (i) Has the potential to exceed an amount determined by the director or exceeds the limit set by the company, whichever is less; (ii) Involves a coverage dispute;

(iii) May exceed the MGA's claims settlement authority; (iv) Is open for more than six (6) months; or (v) Is closed by payment of an amount set by the director or an amount set by the company, whichever is less.

(c) All claims files will be the joint property of the insurer and MGA. However, upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estates. The MGA shall have reasonable access to and the right to copy the files on a timely basis.

(d) Any settlement authority granted to the MGA may be terminated for cause upon the insurer's written notice to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(8) Where electronic claims files are in existence, the contract must address the timely transmission of the data.

(9) If the contract provides for a sharing of interim profits by the MGA, and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the MGA until one (1) year after they are earned for property insurance business and five (5) years after

they are earned on casualty business and not until the profits have been verified pursuant to [section 41-1505, Idaho Code](#).

(10) The MGA shall not:

(a) Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with whom such automatic agreements are in effect, the coverages and amounts of percentages that may be reinsured and commission schedules; (b) Commit the insurer to participate in insurance or reinsurance syndicates; (c) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which he is appointed; (d) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent (1%) of the insurer's policyholders surplus as of December 31 of the last completed calendar year; (e) Collect any payment from a reinsurer or commit the insurer to any claims settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer; (f) Permit its subagent to serve on the insurer's board of directors; (g) Jointly employ an individual who is employed with the insurer; or (h) Appoint a sub-MGA.

History.

[I.C., § 41-1504](#), as added by 1991, ch. 293, § 1, p. 754.

STATUTORY NOTES

Prior Laws.

Former § 41-1504 was repealed. See Prior Laws, § 41-1501.

§ 41-1505. Duties of insurers. — (1) The insurer shall have on file an independent financial examination, in a form acceptable to the director, of each MGA with whom it has done business.

(2) If a MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This is in addition to any other required loss reserve certification.

(3) The insurer shall conduct an on-site review of the underwriting and claims processing operations of the MGA on a semiannual or more frequent basis.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the MGA.

(5) Within thirty (30) days of entering into or termination of a contract with a MGA, the insurer shall provide written notification of such appointment or termination to the director. Notices of appointment of a MGA shall include:

(a) A statement of duties which the applicant is expected to perform on behalf of the insurer;

(b) The lines of insurance for which the applicant is to be authorized to act; and

(c) Any other information the director may request.

(6) An insurer shall review its books and records each quarter to determine if any agent has become, by operation of the provisions of section 41-1502(3) and (4), Idaho Code, a MGA as defined in that section. If the insurer determines that an agent has become a MGA pursuant to the above, the insurer shall promptly notify the agent and the director of such determination and the insurer and agent must fully comply with the provisions of this chapter within thirty (30) days.

(7) An insurer shall not appoint to its board of directors an officer, director, employee, agent or controlling shareholder of its MGA. The

provisions of this subsection shall not apply to relationships governed by chapter 38, title 41, Idaho Code.

History.

I.C., § 41-1505, as added by 1991, ch. 293, § 1, p. 754.

STATUTORY NOTES

Prior Laws.

Former § 41-1505 was repealed. See Prior Laws, § 41-1501.

§ 41-1506. Examination authority. — The acts of the MGA are considered to be the acts of the insurer on whose behalf it is acting. A MGA may be examined pursuant to the insurance statutes and regulations as if it were the insurer.

History.

I.C., § 41-1506, as added by 1991, ch. 293, § 1, p. 754.

STATUTORY NOTES

Prior Laws.

Former § 41-1506 was repealed. See Prior Laws, § 41-1501.

§ 41-1507. Penalties and liabilities. — (1) If the director finds, after a hearing conducted in accordance with the insurance code and the regulations and procedures adopted by the Idaho department of insurance, that any person, firm, association or corporation has violated any provision of this chapter, the director may order:

(a) For each separate violation, a penalty in an amount not to exceed ten thousand dollars (\$10,000); (b) Revocation or suspension of the agent's license; and (c) The MGA to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of the provisions of this chapter committed by the MGA.

(2) Nothing contained in this section shall affect the right of the director to impose any other penalties provided for in the insurance statutes.

(3) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and auditors.

History.

I.C., § 41-1507, as added by 1991, ch. 293, § 1, p. 754.

STATUTORY NOTES

Prior Laws.

Former § 41-1507 was repealed. See Prior Laws, § 41-1501.

Compiler's Notes.

Section 4 of S.L. 1991, ch. 293 read: "The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act."

Chapter 16

WORKER'S COMPENSATION RATES

Sec.

41-1601. Scope of chapter.

41-1602. Declaration of policy — Purpose.

41-1603. Rate-making factors.

41-1604. Rate standard.

41-1605. Uniformity.

41-1606. Rate filings required.

41-1607. Exemption from filing.

41-1608. Effective date of filing.

41-1609. Disapproval of filing within the waiting period.

41-1610. Subsequent disapproval of filing.

41-1611. Scope of disapproval power.

41-1612. Adherence to filings.

41-1613. Excess rates.

41-1614. Deviations.

41-1615. Rating organization membership required.

41-1616. Rating organization minimum membership.

41-1617. Rating organization committees.

41-1618. Applicability of chapter as to certain powers of state insurance manager, and to certain public employment. [Repealed.]

41-1619. Other provisions applicable.

41-1620. Rating organizations.

41-1621. Appeal by minority.

41-1622. Information to insureds — Review of insured's complaint.

41-1623. Appeal from filing.

41-1624. Cooperation among rating organizations and insurers.

41-1625. Hearings and appeal — Scope of provisions. [Repealed.]

41-1626. Compensation reimbursement option.

§ 41-1601. Scope of chapter. — (1) This chapter applies as to worker's compensation insurance as defined in [section 41-506\(1\)\(d\), Idaho Code](#), and to insurance or guaranty by surety insurers of the obligations of employers under worker's compensation laws.

(2) This chapter shall not apply as to any domestic reciprocal insurer transacting worker's compensation insurance only and insuring solely the hazards or perils of its subscribers exclusively associated with a single industry. However, if such a domestic reciprocal insurer transacting worker's compensation insurance wishes to insure hazards or perils outside a single industry, insurance written on such different hazards shall be subject to the provisions of this chapter.

History.

1961, ch. 330, § 362, p. 645; am. 1999, ch. 286, § 1, p. 711.

CASE NOTES

Cited [Whitney v. Continental Life & Acc. Co., 89 Idaho 96, 403 P.2d 573 \(1965\)](#).

§ 41-1602. Declaration of policy — Purpose. — (1) It is declared that the public welfare is served by the making of premium rates for workmen's [worker's] compensation insurance coverages in concert, and that the review by the state of the rates so made is necessary and desirable in the public interest.

(2) It is the purpose of this chapter: (a) To authorize such rate-making in concert, and the operation of rating organizations relative thereto; (b) To establish the general bases and standards for the making of such rates; (c) To provide for review by the state of such rate-making and the results thereof.

History.

1961, ch. 330, § 363, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in subsection (1) was added by the compiler to reflect the current provisions of Title 72, Idaho Code.

§ 41-1603. Rate-making factors. — All rates shall be made in accordance with the following provisions:

(1) Due consideration shall be given to past and prospective loss experience within and outside this state, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors within and outside this state;

(2) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable;

(3) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates on individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

History.

1961, ch. 330, § 364, p. 645.

Idaho Code § 41-1604

§ 41-1604. Rate standard. — Rates shall not be excessive, inadequate or unfairly discriminatory.

History.

1961, ch. 330, § 365, p. 645.

§ 41-1605. Uniformity. — Except to the extent necessary to meet the provisions of section 41-1604[, Idaho Code], uniformity among insurers in any matter within the scope of sections 41-1603 and 41-1604[, Idaho Code,] is neither required nor prohibited.

History.

1961, ch. 330, § 366, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions were added by the compiler to conform to the statutory citation style.

§ 41-1606. Rate filings required. — (1) There shall be filed with the director on behalf of every insurer writing workmen's [worker's] compensation coverages in this state, every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use. Every such filing shall state the proposed effective date thereof, and shall indicate the character and extent of the coverage contemplated. When a filing is not accompanied by the information upon which the filing is supported, and the director does not have sufficient information to determine whether such filing meets the requirements of this chapter, he shall require the insurer's rating organization or the insurer to furnish the information upon which it supports the filing and in such event the waiting period shall commence as of the date such information is furnished. The information furnished in support of a filing may include (a) the experience or judgment of the insurer, (b) the insurer's or rating organization's interpretation of any statistical data relied upon, (c) the experience of other insurers or rating organizations, or (d) any other relevant factors.

(2) A filing and any supporting information shall be open to public inspection after the filing becomes effective.

History.

1961, ch. 330, § 367, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in the first sentence in subsection (1) was added by the compiler to reflect the current provisions of Title 72, Idaho Code.

§ 41-1607. Exemption from filing. — Under such rules and regulations as he shall adopt the director may, by written order, suspend or modify the requirements of filing as to any kind of insurance, subdivision or combination thereof, or as to classes or risks, the rates for which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The director may make such examination as he may deem advisable to ascertain whether any rates affected by such order meet the standards set forth in section 41-1604[, Idaho Code].

History.

1961, ch. 330, § 368, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of the section was added by the compiler to conform to the statutory citation style.

§ 41-1608. Effective date of filing. — (1) The director shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

(2) Subject to the exception specified in subsection (3) below, each filing shall be on file for a waiting period of sixty (60) days before it becomes effective. Upon the written application by the insurer or rating organization, the director may authorize a filing which he has reviewed to become effective before expiration of the waiting period. A filing shall be deemed to meet the requirements of this chapter unless disapproved by the director within the waiting period or any extension thereof.

(3) Any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order, rule or regulation of a public body, not covered by a previous filing, shall become effective when filed and shall be deemed to meet the requirements of this chapter until such time as the director reviews the filing and so long thereafter as the filing remains in effect.

History.

1961, ch. 330, § 369, p. 645; am. 1979, ch. 186, § 1, p. 544.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1609. Disapproval of filing within the waiting period. — If within the waiting period or any extension thereof as provided in section 41-1608(2)[, Idaho Code], the director finds that a filing does not meet the requirements of this chapter, he shall send to the rating organization which made the filing written notice of disapproval of the filing specifying therein in what respects he finds the filing fails to meet the requirements of this chapter and stating that the filing shall not become effective.

History.

1961, ch. 330, § 370, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Following its amendment in 1979, § 41-1608(2) no longer contains provisions relating to extension of the waiting period before a filing becomes effective.

The bracketed insertion near the beginning of the section was added by the compiler to conform to the statutory citation style.

§ 41-1610. Subsequent disapproval of filing. — If any time subsequent to the applicable review period provided for in [section 41-1608\(2\), Idaho Code](#), the director finds that a filing does not meet the requirements of this chapter, he shall after a hearing held in accordance with chapter 2, title 41, Idaho Code, to every rating organization which made the filing, issue an order specifying in what respects he finds that the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. Copies of the order shall be sent to every such rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

History.

1961, ch. 330, § 371, p. 645; am. 2005, ch. 77, § 16, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1611. Scope of disapproval power. — No manual of classifications, rules, rating plan, or any modification of any of the foregoing which establishes standards for measuring variations in hazards or expense provisions, or both, and which has been filed pursuant to the requirements of section 41-1606[, Idaho Code,] shall be disapproved if the rates thereby produced meet the requirements of this chapter.

History.

1961, ch. 330, § 372, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of the section was added by the compiler to conform to the statutory citation style.

§ 41-1612. Adherence to filings. — (1) No insurer shall issue, renew, or continue in force in this state any worker's compensation insurance at premium rates which are less than the rates applicable under the filings in effect for the insurer, or in effect in accordance with section 41-1607 (exemption from filing) or 41-1613 (excess rates), Idaho Code.

(2) No filing shall contain a minimum premium that is less than one hundred fifty dollars (\$150) or greater than three hundred dollars (\$300).

(3) With respect to determination of premiums for partnerships and sole proprietorships, filings shall include a premium calculated on an annual salary of thirteen thousand dollars (\$13,000).

History.

1961, ch. 330, § 373, p. 645; am. 1996, ch. 194, § 1, p. 604.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

Section 5 of S.L. 1996, ch. 194 as amended by § 1 of S.L. 1996, ch. 372 read: "Subsections (2) and (3) of **Section 41-1612, Idaho Code**, as added by the provisions of Section 1 of this act shall be reviewed by the Legislature during the regular legislative session in 2001, for their adequacy in relation to worker's compensation rates."

Effective Dates.

Section 6 of S.L. 1996, ch. 194 provided that the act should be in full force and effect on and after January 1, 1997.

CASE NOTES

Breach of Contract.

The district court did not err in dismissing breach of contract claims, where the plaintiff did not allege a breach of contract with regard to the

issuance of policies by the state insurance fund at lower premiums, and where such premiums were specifically authorized by the statute. *Kelso & Irwin, P.A. v. State Ins. Fund*, 134 Idaho 130, 997 P.2d 591 (2000).

§ 41-1613. Excess rates. — Upon the written application of the insured, stating his reasons therefor, filed with and approved by the director, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

History.

1961, ch. 330, § 374, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1614. Deviations. — (1) Every member of a rating organization shall adhere to the filings made on its behalf by such organization except that any such insurer may make written application to the director for permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system so filed for a kind of insurance or for a class of insurance which is found by the director to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of a kind of insurance (a) comprised of a group of manual classifications which is treated as a separate unit for rate-making purposes, or (b) for which separate expense provisions are included in the filings of the rating organization. Such applications shall specify the basis for the modification and shall be accompanied by the data upon which the applicant relies. A copy of the application and data shall be sent simultaneously to such rating organization.

(2) The director shall set a time and place for a hearing at which the insurer and such rating organization may be heard and shall give them notice thereof in accordance with chapter 2, title 41, Idaho Code. In the event the director is advised by the rating organization that it does not desire a hearing he may, upon the consent of the applicant, waive such hearing. In permitting or denying such modification with respect to worker's compensation insurance the director shall give consideration to the operating methods and expense provisions of the insurer as compared with the expense provisions included in the rating system filed by such rating organization.

(3) The director shall issue an order permitting the modification for such insurer to be filed if he finds it to be justified and it shall thereupon become effective. He shall issue an order denying such application if he finds that the modification is not justified or that the resulting premiums would be excessive, inadequate or unfairly discriminatory.

(4) Each deviation permitted to be filed shall be effective for a period of one (1) year from the date of such permission unless terminated sooner with the approval of the director.

History.

1961, ch. 330, § 375, p. 645; am. 2005, ch. 77, § 17, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1615. Rating organization membership required. — Every insurer, including the Idaho state insurance fund, writing workmen's [worker's] compensation insurance in this state shall be a member of a workmen's [worker's] compensation rating organization. No insurer may at the same time belong to more than one rating organization with respect to such insurance.

History.

1961, ch. 330, § 376, p. 645.

STATUTORY NOTES

Cross References.

State insurance fund, § 72-901 et seq.

Compiler's Notes.

The bracketed insertions in the first sentence in this section were added by the compiler to reflect the current provisions of Title 72, Idaho Code.

§ 41-1616. Rating organization minimum membership. — Such a rating organization shall have as members not less than five (5) insurers authorized to write and writing workmen's [worker's] compensation insurance in this state, and whose combined experience is determined by the director to be reasonably adequate for rate-making purposes.

History.

1961, ch. 330, § 377, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the middle of this section was added by the compiler to reflect the current provisions of Title 72, Idaho Code.

§ 41-1617. Rating organization committees. — In a rating organization of which the Idaho state insurance fund is a member, the Idaho state insurance fund shall be entitled, without election, to membership on any committee thereof established in connection with the operation of the rating organization in this state. One-half (½) of the members of each such committee shall be chosen by the stock insurers and one-half (½) by the non-stock insurers.

History.

1961, ch. 330, § 378, p. 645.

STATUTORY NOTES

Cross References.

State insurance fund, § 72-901 et seq.

§ 41-1618. Applicability of chapter as to certain powers of state insurance manager, and to certain public employment. [Repealed.]

Repealed by S.L. 2014, ch. 95, § 2, effective July 1, 2014.

History.

1961, ch. 330, § 379, p. 645.

§ 41-1619. Other provisions applicable. — Subject to the express provisions of this chapter, the following sections of chapter 14, title 41, Idaho Code, shall, to the extent so applicable, also apply as to this chapter:

- (1) Section 41-1421[, Idaho Code] (technical services).
- (2) Section 41-1425[, Idaho Code] (advisory organizations).
- (3) Section 41-1426[, Idaho Code] (joint underwriting or joint reinsurance).
- (4) Section 41-1427[, Idaho Code] (examination of rating, advisory, and joint reinsurance organizations).
- (5) Section 41-1428[, Idaho Code] (recording, reporting of loss and expense experience).
- (6) Section 41-1429[, Idaho Code] (interchange of data, consultation).
- (7) Section 41-1431[, Idaho Code] (false, misleading information).
- (8) Section 41-1432[, Idaho Code] (penalties for violations, noncompliance).
- (9) Section 41-1433[, Idaho Code] (rules and regulations).
- (10) Section 41-1434[, Idaho Code] (hearing procedure).

History.

1961, ch. 330, § 380, p. 645; am. 1969, ch. 306, § 19, p. 917; am. 2005, ch. 77, § 18, p. 258.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in subsections (1) through (10) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1620. Rating organizations. — (1) A corporation, an unincorporated association, a partnership or an individual, whether located within or outside this state, may make application to the director for license as a rating organization for such kinds of insurance or subdivisions thereof which are subject to this chapter as are specified in its application, and shall file therewith: (a) a copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules and regulations governing the conduct of its business; (b) a list of its members and subscribers; (c) the name and address of a resident of this state upon whom notices or orders of the director or process affecting such rating organization may be served; and (d) a statement of its qualifications as a rating organization. If the director finds that the applicant is competent, trustworthy and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws, rules and regulations governing the conduct of its business conform to the requirements of law, he shall issue a license specifying the kinds of insurance or subdivisions thereof for which the applicant is authorized to act as a rating organization. Every such application shall be granted or denied in whole or in part by the director within sixty (60) days of the date of its filing with him. Licenses issued pursuant to this section shall remain in effect for one (1) year unless sooner suspended or revoked by the director. The fee for the license shall be as provided by rule pursuant to [section 41-401, Idaho Code](#). Licenses issued pursuant to this section may be suspended or revoked by the director, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this subsection. Every rating organization shall notify the director promptly of every change in: (a) its constitution, its articles of agreement or association or its certificate of incorporation, and its bylaws, rules and regulations governing the conduct of its business; (b) its list of members and subscribers; and (c) the name and address of the resident of this state designated by it upon whom notices or orders of the director or process affecting such rating organization may be served.

(2) Subject to rules and regulations which have been approved by the director as reasonable, each rating organization shall permit any insurer, not

a member, to be a subscriber to its rating services for any kind of insurance or subdivision thereof for which it is authorized to act as a rating organization. Notice of proposed changes in such rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber or any such insurer, be reviewed by the director at a hearing held upon notice to such rating organization and to such subscriber or insurer in accordance with chapter 2, title 41, Idaho Code. If the director finds that such rule or regulation is unreasonable in its application to subscribers, he shall order that such rule or regulation shall not be applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within thirty (30) days after it was made, the insurer may request a review by the director as if the application had been rejected. If the director finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization was justified, he shall make an order affirming its action.

(3) Every member of or subscriber to a rating organization shall adhere to the rating organization's manuals of classifications, rules, rates, rating plans and any modifications of any of the foregoing, except to the extent that the rules of such rating organizations permit departures therefrom.

(4) No rating organization shall adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

History.

I.C., § 41-1620, as added by 1969, ch. 306, § 20, p. 917; am. 2001, ch. 85, § 6, p. 211; am. 2005, ch. 77, § 19, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1621. Appeal by minority. — (1) Any member of or subscriber to a rating organization may appeal to the director from the action or decision of the rating organization in approving or rejecting any proposed change in or addition to the filings of the rating organization and the director shall, after a hearing held upon notice to the appellant and to the rating organization in accordance with chapter 2, title 41, Idaho Code, issue an order approving the action or decision of the rating organization or directing it to give further consideration to such proposal, or, if such appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, he may, in the event he finds that such action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with his findings, within a reasonable time after the issuance of such order.

(2) If such appeal is based upon the failure of the rating organization to make a filing on behalf of such member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in [section 41-1603\(2\), Idaho Code](#), from the system of expense provisions included in a filing made by the rating organization, the director shall, if he grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding such appeal the director shall apply the standards set forth in sections 41-1603 and 41-1604, Idaho Code.

History.

[I.C., § 41-1621](#), as added by 1969, ch. 306, § 21, p. 917; am. 2005, ch. 77, § 20, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1622. Information to insureds — Review of insured's complaint.

— (1) Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charges as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

(2) Every rating organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his authorized representative, on his written request to review the manner in which such rating system has been applied in connection with the insurance afforded him. If the rating organization or insurer fails to grant or reject such request within thirty (30) days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any party affected by the action of such rating organization or such insurer on such request may, within thirty (30) days after written notice of such action, appeal to the director, who, after a hearing held upon notice to the appellant and to such rating organization or insurer in accordance with chapter 2, title 41, Idaho Code, may affirm or reverse such action.

History.

I.C., § 41-1622, as added by 1969, ch. 306, § 22, p. 917; am. 2005, ch. 77, § 21, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1623. Appeal from filing. — (1) Any person or organization aggrieved with respect to any filing which is in effect may make written application to the director for a hearing thereon, provided, however, that the insurer or rating organization that made the filing shall not be authorized to proceed under this section. Such application shall specify the grounds to be relied upon by the applicant. If the director finds that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding such a hearing, he shall hold a hearing upon notice to the applicant and to every insurer and rating organization which made the filing in accordance with chapter 2, title 41, Idaho Code.

(2) If, after such hearing, the director finds that the filing does not meet the requirements of the law he shall issue an order specifying in what respects he finds that such filing fails to meet the requirements of law, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of the order shall be sent to the applicant and to every such insurer and rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

History.

I.C., § 41-1623, as added by 1969, ch. 306, § 23, p. 917; am. 2005, ch. 77, § 22, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1624. Cooperation among rating organizations and insurers. — Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is hereby authorized, providing the filings resulting from such cooperation are subject to all the provisions of this chapter which are applicable to filings generally. The director may review such cooperative activities and practices and if, after a hearing, he finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of law, he may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of law, and requiring the discontinuance of such activity or practice.

History.

I.C., § 41-1624, as added by 1969, ch. 306, § 24, p. 917.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1625. Hearings and appeal — Scope of provisions. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-1625, as added by 1969, ch. 306, § 25, p. 917, was repealed by S.L. 2005, ch. 77, § 23.

§ 41-1626. Compensation reimbursement option. — Notwithstanding any other provision of this code, an insurer issuing a worker's compensation insurance contract may include as part of the contract an option allowing a policyholder at the policyholder's sole discretion, to reimburse the insurer for compensation in amounts not to exceed one thousand dollars (\$1,000) per claim, subject to the following conditions:

(1) Claimant's rights shall be properly protected, and claimant's benefits have been paid by the insurer.

(2) The insurer shall pay all benefits of a compensable claim to the person or provider entitled to benefits regardless of the policyholder's option to reimburse the insurer for the claim. Payment of benefits shall not be delayed due to the decision of a policyholder to reimburse the insurer for the claim.

(3) The making of such reimbursement does not constitute a waiver or transfer of the insurer's duty to determine entitlement to benefits.

(4) In the event the insurer recovers any medical costs on a claim reimbursed pursuant to this section, the insurer shall repay the policyholder within thirty (30) days an amount equal to recovered medical costs.

(5) The claim to which a reimbursement by the policyholder applies may not exceed one thousand dollars (\$1,000) over the life of the claim. Should a claim exceed the one thousand dollar (\$1,000) limit after a portion has been reimbursed by the policyholder, the insurer shall within thirty (30) days notify the policyholder and return the reimbursement and adjust all reports accordingly.

(6) The policyholder shall make all reports of accidents, injuries and losses to the insurer as required under the provisions of title 72, Idaho Code, regardless of the policyholder's intent to reimburse the insurer.

(7) The insurer shall record and report all losses for the purpose of setting industry rates.

(8) Claims reimbursed pursuant to this section shall not be reported to a rating organization for the purpose of determining the policyholder's

experience rating, nor shall the insurer otherwise increase a policyholder's experience rating or otherwise make charges against the policyholder for any compensation reimbursed by the policyholder pursuant to this section.

(9) No reduction in current premium may be granted as a result of a reimbursed claim.

(10) Nothing in this section shall apply to worker's compensation insurance contracts offering the policyholder a deductible pursuant to the provisions of title 72, Idaho Code.

(11) If the insurer offers the reimbursement option and the policyholder elects to exercise such option, the procedure for reimbursement shall be as follows:

(a) Within thirty (30) days following each three (3) month period after policy inception or a period mutually agreed upon by the policyholder and the insurer, the insurer shall provide the policyholder with a list of all accepted nondisabling claims for which payments were made during that period and the respective cost of each claim.

(b) No later than thirty (30) days after receipt of the list, the policyholder shall identify the claims and the dollar amount the policyholder elects to reimburse for that period, and the policyholder shall reimburse the insurer accordingly.

(c) Failure by the policyholder to reimburse the insurer within the thirty (30) days allowed shall be deemed notice to the insurer that the policyholder has not elected to make any reimbursement for that period.

History.

I.C., § 41-1626, as added by 1999, ch. 278, § 1, p. 692.

Chapter 17
BUSINESS TRANSACTED WITH BROKER CONTROLLED
INSURER

Sec.

41-1701. Short title.

41-1702. Definitions.

41-1703. Applicability.

41-1704. Minimum standards.

41-1705. Disclosure.

41-1706. Penalties.

§ 41-1701. Short title. — This chapter may be cited as the “Business Transacted with Broker Controlled Insurer Act.”

History.

I.C., § 41-1701, as added by 1993, ch. 194, § 12, p. 492.

STATUTORY NOTES

Prior Laws.

Former sections 41-1701 through 41-1712, comprising S.L. 1961, ch. 330, §§ 381 to 392, were repealed by S.L. 1969, ch. 306, § 26.

Compiler’s Notes.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

Section 37 of S.L. 1993, ch. 194 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

Effective Dates.

Section 13 of S.L. 1993, ch. 194 read: “Section 12 of this act shall take effect on July 1, 1993. Controlled insurers and controlling brokers who are not in compliance with **section 41-1704, Idaho Code**, on its effective date

shall have sixty (60) days to come into compliance and shall comply with [section 41-1705, Idaho Code](#), beginning with all policies written or renewed on or after August 30, 1993.”

§ 41-1702. Definitions. — As used in this chapter:

(1) “Accredited state” means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the national association of insurance commissioners (NAIC).

(2) “Broker” means an insurance broker or brokers or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, such person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation.

(3) “Control” or “controlled” has the meaning ascribed in [section 41-3802\(2\), Idaho Code](#).

(4) “Controlled insurer” means a licensed insurer which is controlled, directly or indirectly, by a broker.

(5) “Controlling broker” means a broker who, directly or indirectly, controls an insurer.

(6) “Licensed insurer” or “insurer” means any person, firm, association or corporation duly licensed to transact a property/casualty insurance business in this state. The following inter alia are not licensed insurers for the purposes of this chapter:

(a) All risk retention groups as defined in the superfund amendments reauthorization act of 1986, [P.L. 99-499, 100 Stat. 1613](#) (1986) and the risk retention act [15 U.S.C. section 3901 et seq. \(1982 and supp. 1986\)](#) and chapter 48, title 41, Idaho Code;

(b) All residual market pools and joint underwriting authorities or associations; and

(c) All captive insurers. For purposes of this chapter, captive insurers are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance

organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and/or group members and their affiliates.

History.

I.C., § 41-1702, as added by 1993, ch. 194, § 12, p. 492; am. 2013, ch. 266, § 9, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-1702 was repealed. See Prior Laws, § 41-1701.

Amendments.

The 2013 amendment, by ch. 266, updated the statutory reference in subsection (3) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Federal References.

The superfund amendments reauthorization act of 1986, referred to in paragraph (6)(a), is compiled throughout titles 10, 26, 29, 33, and 42 of the United States Code.

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (1), see *<http://naic.org>*.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1703. Applicability. — This chapter shall apply to licensed insurers as defined in [section 41-1702, Idaho Code](#), either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of chapter 38, title 41, Idaho Code, to the extent they are not superseded by this chapter, shall continue to apply to all parties within holding company systems subject to the provisions of this chapter.

History.

[I.C., § 41-1703](#), as added by 1993, ch. 194, § 12, p. 492.

STATUTORY NOTES

Prior Laws.

Former § 41-1703 was repealed. See Prior Laws, § 41-1701.

Compiler's Notes.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-1704. Minimum standards. — (1) The provisions of this section:

(a) Shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling broker is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurers' quarterly statement filed as of September 30 of the prior year.

(b) Notwithstanding paragraph (a) of this subsection, the provisions of this section shall not apply if:

(i) The controlling broker:

1. Places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

2. Accepts insurance placements only from nonaffiliated subbrokers, and not directly from insureds; and

(ii) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling broker, a broker controlled by a controlled insurer, or a broker that is a subsidiary of the controlled insurer.

(2) Required contract provisions. A controlled insurer shall not accept business from a controlling broker and a controlling broker shall not place business with a controlled insurer unless there is a written contract between the controlling broker and the insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(a) The controlled insurer may terminate the contract for cause, upon written notice to the controlling broker. The controlled insurer shall suspend the authority of the controlling broker to write business during the pendency of any dispute regarding the cause for the termination;

(b) The controlling broker shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling broker;

(c) The controlling broker shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety (90) days after the effective date of any policy placed with the controlled insurer under this contract;

(d) All funds collected for the controlled insurer's account shall be held by the controlling broker in a fiduciary capacity, in one (1) or more appropriately identified bank accounts in banks that are members of the federal reserve system, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling broker not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling broker's domiciliary jurisdiction;

(e) The controlling broker shall maintain separately identifiable records of business written for the controlled insurer;

(f) The contract shall not be assigned in whole or in part by the controlling broker;

(g) The controlled insurer shall provide the controlling broker with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling broker shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a broker other than the controlling broker;

(h) The rates and terms of the controlling broker's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by brokers other than controlling brokers. For purposes of this subsection and subsection (2)(g) of this section, examples of "comparable business"

include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business;

(i) If the contract provides that the controlling broker, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one (1) year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subsection (4)(a) of this section;

(j) A limit on the controlling broker's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling broker when the applicable limit is approached and shall not accept business from the controlling broker if the limit is reached. The controlling broker shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(k) The controlling broker may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling broker places with the controlled insurer, except that the controlling broker may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

(3) Audit committee. Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the director to review the adequacy of the insurer's loss reserves.

(4) Reporting requirements.

(a) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the director an opinion of an independent casualty actuary (or such other independent loss reserve specialist acceptable to the director) reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end (including incurred but not reported) on business placed by the broker; and

(b) The controlled insurer shall annually report to the director the amount of commissions paid to the broker, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling brokers for placements of the same kinds of insurance.

History.

I.C., § 41-1704, as added by 1993, ch. 194, § 12, p. 492.

STATUTORY NOTES

Prior Laws.

Former § 41-1704 was repealed. See Prior Laws, § 41-1701.

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 13 of S.L. 1993, ch. 194 read: "Section 12 of this act shall take effect on July 1, 1993. Controlled insurers and controlling brokers who are not in compliance with [section 41-1704, Idaho Code](#), on its effective date shall have sixty (60) days to come into compliance and shall comply with [section 41-1705, Idaho Code](#), beginning with all policies written or renewed on or after August 30, 1993."

§ 41-1705. Disclosure. — The broker, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the broker and the controlled insurer; except that, if the business is placed through a subbroker who is not a controlling broker, the controlling broker shall retain in his records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has or will notify the insured.

History.

I.C., § 41-1705, as added by 1993, ch. 194, § 12, p. 492.

STATUTORY NOTES

Prior Laws.

Former § 41-1705 was repealed. See Prior Laws, § 41-1701.

Effective Dates.

Section 13 of S.L. 1993, ch. 194 read: “Section 12 of this act shall take effect on July 1, 1993. Controlled insurers and controlling brokers who are not in compliance with [section 41-1704, Idaho Code](#), on its effective date shall have sixty (60) days to come into compliance and shall comply with [section 41-1705, Idaho Code](#), beginning with all policies written or renewed on or after August 30, 1993.”

§ 41-1706. Penalties. — (1) If the director believes that the controlling broker or any other person has not materially complied with the provisions of this chapter, or any regulation or order promulgated hereunder, after notice and opportunity to be heard, the director may order the controlling broker to cease placing business with the controlled insurer; and, if it was found that because of such material noncompliance that the controlled insurer or any policyholder thereof has suffered any loss or damage, the director may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to chapter 33, title 41, Idaho Code, and the receiver appointed under that order believes that the controlling broker or any other person has not materially complied with the provisions of this chapter, or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(3) Nothing contained in this section shall affect the right of the director to impose any other penalties provided for in the insurance code.

(4) Nothing contained in this section is intended to, or shall in any manner, alter or affect the rights of policyholders, claimants, creditors or other third parties.

History.

I.C., § 41-1706, as added by 1993, ch. 194, § 12, p. 492.

STATUTORY NOTES

Prior Laws.

Former § 41-1706 was repealed. See Prior Laws, § 41-1701.

Compiler's Notes.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

Section 37 of S.L. 1993, ch. 194 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

Effective Dates.

Section 13 of S.L. 1993, ch. 194 read: “Section 12 of this act shall take effect on July 1, 1993. Controlled insurers and controlling brokers who are not in compliance with [section 41-1704, Idaho Code](#), on its effective date shall have sixty (60) days to come into compliance and shall comply with [section 41-1705, Idaho Code](#), beginning with all policies written or renewed on or after August 30, 1993.”

Chapter 18

THE INSURANCE CONTRACT

Sec.

41-1801. Scope of chapter.

41-1802. “Policy” defined.

41-1803. “Premium” defined.

41-1804. Insurable interest — Personal insurance.

41-1805. Life insurance for benefit of certain institutions.

41-1806. Insurable interest — Property.

41-1807. Power to contract — Purchase of insurance by minors.

41-1808. Application required — Life and disability insurance.

41-1809. Alteration of application — Life and disability insurance.

41-1810. Application as evidence.

41-1811. Representations in applications.

41-1812. Filing, use and disapproval of forms.

41-1813. Grounds for disapproval.

41-1814. Standard provisions in general.

41-1815. Contents of policies in general.

41-1816. Assessment policies — Special contents.

41-1817. Additional policy contents.

41-1818. Charter and by-law provisions.

41-1819. Execution of policies.

41-1820. Underwriters’ and combination policies.

41-1821. Validity and construction of noncomplying forms.

41-1822. Construction of policies.

41-1823. Binders.

41-1824. Delivery of policy.

41-1825. Renewal by certificate.

41-1826. Assignment of policies.

41-1827. Right to inspect policies in force.

41-1828. Payment discharges insurer — Payment to marital community.

41-1829. Minor may give acquittance. [Repealed.]

41-1830. Notice of lapse or termination of individual life insurance.

41-1831. Forms for proof of loss to be furnished.

41-1832. Claims administration not waiver.

41-1833. Exemption of proceeds — Life insurance.

41-1834. Exemption of proceeds — Disability insurance.

41-1835. Exemption of proceeds — Group insurance.

41-1836. Exemption of proceeds — Annuity contracts — Assignability of rights.

41-1837. Return of unearned premiums on destruction of property.

41-1838. Venue of suits against insurers.

41-1839. Allowance of attorney's fees in suits against or in arbitration with insurers.

41-1840. Prepayment of claims.

41-1841. Block cancellations and block nonrenewals — Notice to director required.

41-1842. Commercial insurance — Cancellation — Nonrenewal.

41-1843. Insurance rates and credit rating.

41-1844. Prescription drug benefit restrictions prohibited.

41-1845. Recreational-related activities.

41-1846. Health care policies — Applicability — Requirement.

41-1847. Assignment of health insurance contracts.

41-1848. Legislative findings and purpose — Coverage for abortions in state exchange prohibited.

41-1849. Contracts with providers of dental services.

41-1850. Certificates of insurance.

41-1851. Electronic notices and documents.

41-1852. Discrimination against living organ donors prohibited.

§ 41-1801. Scope of chapter. — This chapter applies as to all insurance contracts and annuity contracts, other than:

- (1) Reinsurance.
- (2) Policies or contracts not issued for delivery in this state nor delivered in this state.
- (3) Wet marine and transportation insurance.

Provided, however, that the above stated exceptions shall not apply to section 41-1839[, Idaho Code].

History.

1961, ch. 330, § 393, p. 645; am. 1967, ch. 26, § 1, p. 46.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion at the end of the section was added by the compiler to conform to the statutory citation style.

CASE NOTES

Application of Section.

Subsection (2) of this section did not preclude the application of § 41-1839 to an action against a motor carrier, for damage to household goods in transit from Florida to Idaho, covered by supplementary insurance of the carrier, for which the owner paid together with the freight charges upon delivery of the goods in Idaho, after which the damage was discovered. *Rungee v. Allied Van Lines*, 92 Idaho 718, 449 P.2d 378 (1968).

Cited *Smith v. Great Basin Grain Co.*, 98 Idaho 266, 561 P.2d 1299 (1977); *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

§ 41-1802. “Policy” defined. — “Policy” means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements and papers which are a part thereof.

History.

1961, ch. 330, § 394, p. 645.

CASE NOTES

Valid Endorsements.

So long as endorsements are not obtained fraudulently, do not violate public policy, are supported by consideration and are otherwise valid under Idaho contract and insurance law principles, the courts must give them effect. *Wright v. Johnson*, 101 Idaho 208, 610 P.2d 567 (1980).

Cited *Rungee v. Allied Van Lines*, 92 Idaho 718, 449 P.2d 378 (1968); *Smith v. Great Basin Grain Co.*, 98 Idaho 266, 561 P.2d 1299 (1977); *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987); *County of Kootenai v. Western Cas. & Sur. Co.*, 113 Idaho 908, 750 P.2d 87 (1988).

§ 41-1803. “Premium” defined. — “Premium” is the consideration for insurance by whatever name called. Any “assessment,” or any “membership,” “policy,” “survey,” “inspection,” “service” or similar fee or other charge in consideration for an insurance contract is deemed part of the premium; provided that producer fees charged pursuant to [section 41-1030, Idaho Code](#), shall not be considered a premium unless the fee relates to a surplus line policy.

History.

1961, ch. 330, § 395, p. 645; am. 2001, ch. 154, § 2, p. 557; am. 2002, ch. 359, § 2, p. 1017.

CASE NOTES

Cited [Rungee v. Allied Van Lines, 92 Idaho 718, 449 P.2d 378 \(1968\).](#)

§ 41-1804. Insurable interest — Personal insurance. — (1) Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person. But, except as provided in section 41-1805[, Idaho Code], no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contract are payable to the individual insured or his personal representatives, or to a person having, at the time when such contract was made, an insurable interest in the individual insured.

(2) If the beneficiary, assignee, or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement, or injury of the individual insured, the individual insured or his executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

(3) “Insurable interest” as to personal insurance means that every individual has an insurable interest in the life, body and health of himself, and of other persons as follows: (a) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection; (b) In the case of other persons, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the individual insured; and (c) An individual heretofore or hereafter party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a closed corporation or of an interest in such shares, has an insurable interest in the life of each individual party to such contract and for the purposes of such contract only, in addition to any insurable interest which may otherwise exist as to the life of such individual.

(4) An insurer shall be entitled to rely upon all statements, declarations and representations made by an applicant for insurance relative to the insurable interest of the applicant in the insured; and no insurer shall incur

legal liability except as set forth in the policy, by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

History.

1961, ch. 330, § 396, p. 645.

STATUTORY NOTES

Cross References.

Fiduciaries, investment of funds in life or annuity contracts, § 68-406.

Compiler's Notes.

The bracketed insertion near the middle of subsection (1) was added by the compiler to conform to the statutory citation style.

CASE NOTES

In General.

Because sewer district, a legal entity and political subdivision of the state, cannot sue for or recover damages for personal injuries, insurer for “bodily injury” coverage had no duty to defend construction company in suit by sewer district for deficient construction of sewer line. *Shunn Constr., Inc. v. Royal Ins. Co.*, 127 Idaho 97, 897 P.2d 89 (1995).

RESEARCH REFERENCES

ALR. — An insurable interest for liability insurance. 1 A.L.R.3d 1193.

§ 41-1805. Life insurance for benefit of certain institutions. — (1) Contracts of life insurance may be made and entered into in which the person paying the consideration for such insurance has no insurable interest in the life of the person insured, where charitable, benevolent, educational, or religious institutions are designated irrevocably as the beneficiaries thereof.

(2) In making such contracts the person paying the premium shall make and sign the application therefor as owner and shall designate a charitable, benevolent, educational, or religious institution irrevocably as the beneficiary or beneficiaries of such policy. The application also shall be signed by the person whose life is to be insured.

(3) Such a contract shall be valid and binding between and among all of the parties thereto, and the person paying the consideration for such insurance shall have all rights conferred by the contract to loan value at any time during the premium paying period, but not at maturity, notwithstanding such person has no insurable interest in the life of the person insured.

History.

1961, ch. 330, § 397, p. 645.

§ 41-1806. Insurable interest — Property. — (1) No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss.

(2) “Insurable interest” as used in this section means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.

(3) The measure of an insurable interest in property is the extent to which the insured might be directly damaged by loss, injury, or impairment thereof.

History.

1961, ch. 330, § 398, p. 645.

CASE NOTES

Application.

Application questions.

Beneficial interest.

Construction of contract.

Defense of failure of disclosure.

In general.

Insurable interest not extinguished.

Material omission.

Application.

Applying this section beyond the initial two year period, would render §§ 41-2012 and 41-2015 ineffective and nonexistent, while applying this section only to the first two years of coverage gives meaning and effect to all the statutes; accordingly, this section applies only during the first two

years of coverage. *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

Application Questions.

A question in an application for a family health and accident policy which asked in general whether applicant had ever been medically treated for or medically advised for any other heart or circulatory disorder did not require applicant to disclose her heart murmur of which she had been aware as early as 1947, where there was no evidence that applicant had received any medical treatment for her heart murmur or had been advised by a physician that the heart murmur constituted a “heart disorder.” *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

Where question in application for a family health and accident policy specifically and unambiguously asked applicant whether she had ever been treated for or medically advised for abnormal blood pressure, the insurance company was entitled to disclosure of information that applicant had regarding an earlier diagnosis and medication for her high blood pressure condition, even though applicant was not taking medication at the time of the application. *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

Beneficial Interest.

Where sellers of cabin were listed in insurance binder as having a beneficial interest in insurance policy purchased by buyers, and where the binder contained no words limiting the coverage either to the sellers’ mortgagee interest in the property or to their post-closing losses, the binder unambiguously provided the sellers with a beneficial interest in the insurance. *Holscher v. James*, 124 Idaho 443, 860 P.2d 646 (1993).

Construction of Contract.

Provisions of this statute cannot be applied retroactively in a cause where the loss occurred and the policy was issued prior to its enactment. *Coburn v. Fireman’s Fund Ins. Co.*, 86 Idaho 415, 387 P.2d 598 (1963).

Defense of Failure of Disclosure.

In an action to recover from insurer under a health and accident policy for medical expenses resulting from hospitalization and heart surgery,

where applicant testified that she told insurer's agent who filled out the application about her high blood pressure condition but where the agent testified that he could not remember being so advised, the trial court was required to make findings of fact and conclusions of law on the issue, for an affirmative finding for the applicant would have been a bar to insurer's affirmative defense of failure of disclosure. *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

In General.

One to whom the owner of a cabin on forest service land had given the right to use the cabin, without consideration beyond the relationship of the donee as son-in-law to the owner, and to whom the owner planned to leave the cabin in her will did not have a "substantial economic interest" constituting an insurable interest as defined in this section. *Boston Ins. Co. v. Beckett*, 91 Idaho 220, 419 P.2d 475 (1966).

Where a man made an oral agreement to sell a truck to a corporation but, because of the informality of the transaction, either party could have refused to go through with it, the corporation had no insurable interest in the truck under this section. *Keller Lorenz Co. v. Insurance Assocs. Corp.*, 98 Idaho 678, 570 P.2d 1366 (1977).

Insurable Interest Not Extinguished.

A dispute over the purchase contract did not extinguish the plaintiffs' insurable interest because the plaintiffs did not lose an ownership right in the house by any legal process that would terminate their insurable interest in the property, and possession was not required for the plaintiffs to retain an insurable interest in the house. *Rhead v. Hartford Ins. Co.*, 135 Idaho 446, 19 P.3d 760 (2001).

Material Omission.

In an action to recover from insurer under a health and accident policy for medical expenses resulting from hospitalization and heart surgery, whether the nondisclosure of applicant's high blood pressure and her taking of medication for the condition was an omission so material to insurer's acceptance of the risk as to prevent applicant's recovery was a question to be determined by the trier of fact. *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

§ 41-1807. Power to contract — Purchase of insurance by minors. —

(1) Any person of competent legal capacity may contract for insurance.

(2) Any minor not less than fifteen (15) years of age, notwithstanding his minority, may contract for annuities or for insurance upon his own life, body, health, property, liabilities or other interests, or on the person of another in whom the minor has an insurable interest. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under (a) any contract for annuity or for insurance upon his own life, body or health, or (b) any contract such minor effected upon his own property, liabilities or other interests, or on the person of another, as might be exercised by a person of full legal age, and may at any time surrender his interest in any such contracts and give valid discharge for any benefit accruing or money payable thereunder. Such a minor shall not, by reason of his minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such a minor not otherwise emancipated, shall not be bound by any unperformed agreement to pay by promissory note or otherwise, any premium on any such annuity or insurance contract.

(3) Any annuity contract or policy of life or disability insurance procured by or for a minor under subsection (2) above, shall be made payable either to the minor or his estate or to a person having an insurable interest in the life of the minor.

History.

1961, ch. 330, § 399, p. 645; am. 1977, ch. 142, § 7, p. 303.

CASE NOTES

Age of Majority.

Since the discrimination between males and females under § 32-101 concerning the age at which they reach majority has been held unconstitutional and males reach their majority at 18, when deceased became an insured under a group life insurance policy at age 18, he was not

a minor and was competent to designate defendant as beneficiary under the policy. [Aue v. Ericks, 96 Idaho 13, 523 P.2d 830 \(1974\)](#).

§ 41-1808. Application required — Life and disability insurance. —
No life or disability insurance contract upon an individual, except a contract of group life insurance or of group or blanket disability insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

- (1) A spouse may effectuate such insurance upon the other spouse.
- (2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of or pertaining to such minor.
- (3) Family policies may be issued insuring any two (2) or more members of a family on an application signed by either parent, a stepparent, or by a husband or wife.

History.

1961, ch. 330, § 400, p. 645.

§ 41-1809. Alteration of application — Life and disability insurance.

— No alteration of any written application for any life or disability insurance policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

History.

1961, ch. 330, § 401, p. 645.

§ 41-1810. Application as evidence. — (1) No application for the issuance of any life or disability insurance policy or annuity contract shall be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to or otherwise made a part of the policy or contract when issued. This provision shall not apply to industrial life insurance policies.

(2) If any policy of life or disability insurance delivered in this state is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within thirty (30) days after receipt of such request at its home office, deliver or mail to the person making such request a copy of such application reproduced by any legible means. If such copy is not so delivered or mailed after having been so requested, the insurer shall be precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal. In the case of such a request from a beneficiary, the time within which the insurer is required to furnish a copy of such application shall not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's vested interest in the policy or contract.

(3) As to kinds of insurance other than life or disability insurance, no application for insurance signed by or on behalf of the insured shall be admissible in evidence in any action between the insured and the insurer arising out of the policy so applied for, if the insurer has failed, at expiration of thirty (30) days after receipt by the insurer of written demand therefor by or on behalf of the insured, to furnish to the insured a copy of such application reproduced by any legible means.

History.

1961, ch. 330, § 402, p. 645.

§ 41-1811. Representations in applications. — All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:

(a) Fraudulent; or

(b) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or (c) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

History.

1961, ch. 330, § 403, p. 645.

CASE NOTES

Application.

Application questions.

Defense of failure of disclosure.

Employment.

Material omission.

Ownership.

Application.

Applying this section beyond the initial two year period would render §§ 41-2012 and 41-2015 ineffective and nonexistent, while applying this section only to the first two years of coverage gives meaning and effect to all the statutes; accordingly, this section applies only during the first two

years of coverage. *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

Application Questions.

A question in an application for a family health and accident policy which asked in general whether applicant had ever been medically treated for or medically advised for any other heart or circulatory disorder did not require applicant to disclose her heart murmur of which she had been aware as early as 1947, where there was no evidence that applicant had received any medical treatment for her heart murmur or had been advised by a physician that the heart murmur constituted a “heart disorder.” *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

Where question in application for a family health and accident policy specifically and unambiguously asked applicant whether she had ever been treated for or medically advised for abnormal blood pressure, the insurance company was entitled to disclosure of information that applicant had regarding an earlier diagnosis and medication for her high blood pressure condition, even though applicant was not taking medication at the time of the application. *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

Defense of Failure of Disclosure.

In an action to recover from insurer under a health and accident policy for medical expenses resulting from hospitalization and heart surgery, where applicant testified that she told insurer’s agent who filled out the application about her high blood pressure condition but where the agent testified that he could not remember being so advised, the trial court was required to make findings of fact and conclusions of law on the issue, for an affirmative finding for the applicant would have been a bar to insurer’s affirmative defense of failure of disclosure. *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

This section codified the common law defense of fraud and misrepresentation in the insurance contract context and limited its application. Nothing in this section abrogated the common law requirement that a party seeking rescission had to tender back any consideration or

benefit received under the contract. *Robinson v. State Farm Mut. Auto. Ins. Co.*, 137 Idaho 173, 45 P.3d 829 (2002).

Employment.

Where an applicant for group insurance falsely represented himself as being employed at least thirty (30) hours a week by the group employer and evidence was uncertain as to whether the insurer would have insured him if it had known that his employment was for less than thirty (30) hours a week, such issue should have been resolved by the trier of the facts and it was error to render a summary judgment for the beneficiary. *Matthews v. New York Life Ins. Co.*, 92 Idaho 372, 443 P.2d 456 (1968).

Material Omission.

In an action to recover from insurer under a health and accident policy for medical expenses resulting from hospitalization and heart surgery, whether the nondisclosure of applicant's high blood pressure and her taking of medication for the condition was an omission so material to insurer's acceptance of the risk as to prevent applicant's recovery was a question to be determined by the trier of fact. *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976).

Ownership.

Representation by the insured that he was the sole owner of a vehicle was not rendered a misrepresentation by the fact that the insured had an unwritten and indefinite agreement with his brother to transfer the vehicle to him if and when he paid him the purchase price of it and the brother had made some payments but had not completed the purchase of the vehicle at the time of the accident for which claim was made. *Occidental Fire & Casualty Co. v. Cook*, 92 Idaho 7, 435 P.2d 364 (1967).

In case where insurance company insured packing company and several officers thereof as named insureds under comprehensive automobile liability policy, alleged misrepresentation by 18 year old son of one such officer that company owned recently purchased automobile, which son in fact owned, was not material to the risk assumed by the insurance company within the meaning of paragraph (b) of this section, since insurance company knew son was to be principal driver of car and could, therefore, assess risk involved just as accurately as it could had it known the name of

the true owner. *Industrial Indem. Co. v. United States Fid. & Guar. Co.*, 93 Idaho 59, 454 P.2d 956 (1969).

Cited *Dean v. Nationwide Life Ins. Co.*, 96 Idaho 772, 536 P.2d 1122 (1975); *Gulf USA Corp. v. Federal Ins. Co.*, 259 F.3d 1049 (9th Cir. 2001).

RESEARCH REFERENCES

ALR. — Insured's responsibility for false answers inserted by agent in application following correct answers by insured or incorrect answers suggested by agent, 26 A.L.R.3d 6.

Rescission of directors' and officers' liability insurance policy. 29 A.L.R.6th 189.

§ 41-1812. Filing, use and disapproval of forms. — (1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be delivered, or issued for delivery in this state, unless the form has been filed with the director. This provision shall not apply to surety bonds, or to specially rated inland marine risks, nor to policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the director. As to forms for use in property, marine (other than wet marine and transportation insurance), casualty and surety insurance coverages the filing required by this subsection may be made by rating organizations on behalf of its members and subscribers; but this provision shall not be deemed to prohibit any such member or subscriber from filing any such forms on its own behalf.

(2) Every such filing shall be submitted with a certification, in such form as may be determined by the director, by an officer of the insurer that each policy, form, endorsement, or rider in use complies with Idaho law. The director shall have the power to examine such filings to determine whether the policies, forms, endorsements, and riders, as filed, comply with the certification of the insurer and with Idaho law relating to the content of such documents. Upon a determination that any document filed in accordance with this section does not comply with Idaho law, the director shall, in accordance with the Idaho administrative procedure act, prohibit the use of such policy, form, endorsement, rider or other document.

(3) The director may, by order, exempt from the requirements of this section for so long as he deems proper any insurance document or form or type thereof as specified in such order, to which, in his opinion, this section

may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

History.

1961, ch. 330, § 404, p. 645; am. 1982, ch. 148, § 1, p. 412; am. 1995, ch. 137, § 1, p. 591; am. 1997, ch. 344, § 1, p. 1027.

STATUTORY NOTES

Cross References.

Administrative procedure act, § 67-5201 et seq.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Cited [Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 \(Ct. App. 1987\).](#)

§ 41-1813. Grounds for disapproval. — The director shall disapprove any form filed under section 41-1812[, Idaho Code], or withdraw any previous approval thereof, only on one or more of the following grounds:

- (1) Is in any respect in violation of or does not comply with this code.
- (2) Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract, or which are unfairly prejudicial to the policy holder.
- (3) Has any title, heading, or other indication of its provisions which is misleading.
- (4) Is printed or otherwise reproduced in such manner as to render any provision of the form substantially illegible.

History.

1961, ch. 330, § 405, p. 645; am. 1969, ch. 214, § 48, p. 625.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in the introductory paragraph was added by the compiler to conform to the statutory citation style.

CASE NOTES

Cited *Howard v. Blue Cross of Idaho Health Serv., Inc.*, 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

§ 41-1814. Standard provisions in general. — (1) Insurance contracts shall contain such standard or uniform provisions as are required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The director may waive the required use of a particular provision in a particular insurance policy form if:

(a) He finds such provision unnecessary for the protection of the insured and inconsistent with the purposes of the policy, and (b) The policy is otherwise approved by him.

(2) No policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used, but the director may approve any substitute provision which is, in his opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(3) In lieu of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the director.

History.

1961, ch. 330, § 406, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Standard Form Not Exclusive.

Contractual rights of parties were in no way abridged by law prescribing standard form of policy. *Carroll v. Hartford Fire Ins. Co.*, 28 Idaho 466, 154 P. 985 (1916).

RESEARCH REFERENCES

ALR. — Type or color of printing for insurance policies, statutes relating to size and other characteristics of. [36 A.L.R.3d 464](#).

§ 41-1815. Contents of policies in general. — (1) Every policy shall specify:

- (a) The names of the parties to the contract.
- (b) The subject of the insurance.
- (c) The risks insured against.
- (d) The time when the insurance thereunder takes effect and the period during which the insurance is to continue.
- (e) The premium.
- (f) The conditions pertaining to the insurance.

(2) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.

(3) Subsections (1) and (2) above shall not apply as to surety contracts, or to group insurance policies.

History.

1961, ch. 330, § 407, p. 645; am. 1987, ch. 278, § 14, p. 571; am. 1990, ch. 240, § 1, p. 682.

STATUTORY NOTES

Compiler's Notes.

Section 19 of S.L. 1987, ch. 278 read: "The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act."

Effective Dates.

Section 18 of S.L. 1987, ch. 278 read: “The provisions of this act shall take effect on July 1, 1987, provided however, that Section 1 through 11 shall apply only to causes of action which accrue on and after July 1, 1987. Provided further, that [Section 6-1603, Idaho Code](#), as enacted herein, is hereby repealed and does sunset for causes of action which accrue after June 30, 1992.”

§ 41-1816. Assessment policies — Special contents. — Every policy delivered or issued for delivery in this state by an insurer otherwise than authorized under other express provisions of this code to transact such insurance in this state on the assessment plan, together with the form of any application for such a policy to be signed by the applicant, shall have conspicuously printed near the top on the face thereof in boldface type of a size not less than the largest type used for any heading or caption in the policy or application, as applicable, the words “issued on the assessment plan” or “assessment plan”.

History.

1961, ch. 330, § 408, p. 645.

§ 41-1817. Additional policy contents. — A policy may contain additional provisions not inconsistent with this code and which are:

(1) Required to be inserted by the laws of the insurer's domicile; (2) Necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract, or (3) Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein.

History.

1961, ch. 330, § 409, p. 645.

§ 41-1818. Charter and by-law provisions. — No policy shall contain any provision purporting to make any portion of the charter, by-laws or other constituent document of the insurer (other than the subscriber's agreement or power of attorney of a reciprocal insurer) a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid.

History.

1961, ch. 330, § 410, p. 645.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1819. Execution of policies. — (1) Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee, or representative duly authorized by the insurer.

(2) A facsimile signature of any such executing individual may be used in lieu of an original signature.

(3) No insurance contract heretofore or hereafter issued and which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

History.

1961, ch. 330, § 411, p. 645.

§ 41-1820. Underwriters' and combination policies. — (1) Two (2) or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any one (1) insurer may issue policies in the name of an underwriter's department and such policy shall plainly show the true name of the insurer.

(2) Two (2) or more insurers may, with the approval of the director, issue a combination policy which shall contain provisions substantially as follows: (a) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy, and (b) That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers.

(3) This section shall not apply to cosurety obligations.

History.

1961, ch. 330, § 412, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1821. Validity and construction of noncomplying forms. — (1) A policy hereafter delivered or issued for delivery to any person in this state in violation of this code, but otherwise binding on the insurer, shall be held valid, but shall be construed as provided in this code.

(2) Any insurance policy, rider, or endorsement hereafter issued and otherwise valid which contains any condition, omission or provision not in compliance with the requirements of this code, shall not be thereby rendered invalid but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this code.

History.

1961, ch. 330, § 413, p. 645.

§ 41-1822. Construction of policies. — Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application lawfully made a part of the policy.

History.

1961, ch. 330, § 414, p. 645.

CASE NOTES

In general.

Insured.

In General.

In construing insurance policies, as in the construction of other contracts, the entire contract is to be construed together for the purpose of giving force and effect to each clause. *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

Insured.

Where the insurance policy stated that the named insured was a subsidiary of the parent corporation, throughout the remainder of that policy, the named insured was referred to as the subsidiary, et al, and the parent corporation was the named insured under the binder, the parent corporation was a named insured under insurance policy. *Idaho v. Bunker Hill Co.*, 647 F. Supp. 1064 (D. Idaho 1986).

Cited *County of Kootenai v. Western Cas. & Sur. Co.*, 113 Idaho 908, 750 P.2d 87 (1988).

§ 41-1823. Binders. — (1) Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such supplemental information and applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

(2) No binder shall be valid beyond the issuance of the policy, or the endorsement, or the policy expiration, whichever is shortest, with respect to which it was given.

(3) This section shall not apply to life or disability insurances.

History.

1961, ch. 330, § 415, p. 645; am. 2012, ch. 314, § 2, p. 863.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 314, inserted “supplemental information and” in subsection (1); substituted “or the endorsement, or the policy expiration, whichever is shortest, with respect to which it was given” for “with respect to which it was given or beyond ninety (90) days from its effective date, whichever period is the shorter”; deleted former subsection (3), which read, “If the policy has not been issued a binder may be extended or renewed beyond such ninety (90) days with the written approval of the director, or in accordance with such rules and regulations relative thereto as the director may promulgate.”; and renumbered former subsection (4) as present subsection (3).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 3 of S.L. 2012, ch. 314 provided “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act

or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

§ 41-1824. Delivery of policy. — (1) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled thereto within a reasonable period of time after its issuance except where a condition required by the insurer has not been met by the insured.

(2) In event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same such information, shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, adequate notice including, but not limited to, a printed, written, or stamped statement of such fact located conspicuously on the face of such duplicate policy or memorandum shall be provided to the insured, pursuant to rules and regulations adopted by the director of the department of insurance. The director shall prescribe a form, which must be signed by the insured stating that he has received notification as required herein, and by the vendor stating that he has supplied the notification as required herein. This subsection does not apply to inland marine floater policies.

History.

1961, ch. 330, § 416, p. 645; am. 1971, ch. 165, § 1, p. 787.

STATUTORY NOTES

Compiler's Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance and commissioner has been changed

to director on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Failure to Deliver.

Where an insurance agent received \$300 premium payment in exchange for a statement to defendant that he was “covered” and agent never mailed or delivered an insurance policy as required by this section, the insurance company was bound by oral contract without regard to the written terms of the actual policy; thus, there was substantial competent evidence that the insured had first-party coverage protecting him against losses sustained. *Foremost Ins. Co. v. Putzier*, 102 Idaho 138, 627 P.2d 317 (1981).

By failing to comply with the provisions of this section, which require every insurance policy be delivered to the insured, the insurer places itself at risk of having representations made by its agent treated as contract terms. *Chester v. State Farm Ins. Co.*, 117 Idaho 538, 789 P.2d 534 (Ct. App. 1990).

§ 41-1825. Renewal by certificate. — Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable, may be renewed or extended at the option of the insurer and upon a currently authorized policy form and at the premium rate then required therefor, for a specific additional period or periods by certificate or by endorsement of the policy, and without requiring the issuance of a new policy.

History.

1961, ch. 330, § 417, p. 645.

§ 41-1826. Assignment of policies. — A policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or disability policy, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

History.

1961, ch. 330, § 418, p. 645.

§ 41-1827. Right to inspect policies in force. — The director shall have the right to inspect any policy covering any risk in this state, and every policyholder shall produce and exhibit any policy in his possession or control when required for such inspection. Any person who violates this section shall be guilty of a misdemeanor and upon conviction thereof shall be punishable by a fine of not exceeding five hundred dollars (\$500).

History.

1961, ch. 330, § 419, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1828. Payment discharges insurer — Payment to marital community. — (1) Whenever the proceeds of or payments under a life or disability insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by such assignment as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.

(2) Where the person designated in the policy or contract or by assignment as being entitled thereto is a member of a marital community, whether husband or wife, and the policy or contract is upon the life or disability of either, he or she may receive payment, and shall be and is constituted agent of the marital community with authority to give full acquittance therefor; and such payment to the marital community agent so designated shall fully discharge the insurer from all claims under the policy or contract, but no rights of either member of the marital community, as between themselves, to accounting or division shall be impaired or affected by such payment.

History.

1961, ch. 330, § 420, p. 645.

§ 41-1829. Minor may give acquittance. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised S.L. 1961, ch. 330, § 421, p. 645, was repealed by S.L. 1972, ch. 241, § 1.

§ 41-1830. Notice of lapse or termination of individual life insurance.

— (1) Notwithstanding the provisions of [section 41-1927, Idaho Code](#), an individual life insurance policy shall not be issued or delivered in this state until the applicant has been afforded the option of designating one (1) person, in addition to the applicant, to receive notice of lapse or termination of a policy for nonpayment of premium.

(2) A designation made pursuant to subsection (1) of this section shall be on a form provided by the insurer. The applicant shall, on such form, provide the full name, address and telephone number of the person designated to receive notice of lapse or termination of the policy for nonpayment of premium.

(3) The insurer shall annually notify a policy owner of the right to: (a) Make a designation pursuant to subsection (1) of this section; (b) Change the designee; and

(c) Update the contact information of the designee.

(4) The policy owner may, at the policy owner's discretion, change the designee or change the contact information of the designee more often than annually, and the insurer shall make available the form for such changes at the policy owner's request.

(5) No individual life insurance policy shall lapse or be terminated for nonpayment of premium unless the insurer, at least fourteen (14) days prior to the effective date of the lapse or termination, sends notice by first-class United States mail to the policy owner and to the policy owner's designee, if a designation has been made pursuant to this section, of the lapse or termination, at the address or addresses provided by the policy owner for purposes of receiving such notice.

(6) The provisions of this section shall apply to any individual life insurance policy issued or in force on or after January 1, 2018. Provided however, that the provisions of this section do not apply to any life insurance policy under which premiums are payable monthly or more frequently.

History.

I.C., § 41-1830, as added by 2017, ch. 265, § 1, p. 660.

STATUTORY NOTES

Prior Laws.

Former § 41-1830, Life policy as separate property of married woman, which comprised 1961, ch. 330, § 422, p. 645, was repealed by S.L. 2010, ch. 95, § 1, effective July 1, 2010.

§ 41-1831. Forms for proof of loss to be furnished. — An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

History.

1961, ch. 330, § 423, p. 645.

§ 41-1832. Claims administration not waiver. — Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy.

(2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

(3) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

History.

1961, ch. 330, § 424, p. 645.

§ 41-1833. Exemption of proceeds — Life insurance. — (1) If a policy of insurance, whether heretofore or hereafter issued, is effected by any person on his own life, or on another life, in favor of a person other than himself, or, except in cases of transfer with intent to defraud creditors, if a policy of life insurance is assigned or in any way made payable to any such person, the lawful beneficiary or assignee thereof, other than the insured or the person so effecting such insurance or executors or administrators of such insured or the person so effecting such insurance, shall be entitled to its proceeds and avails against the creditors and representatives of the insured and of the person effecting the same, whether or not the right to change the beneficiary is reserved or permitted, and whether or not the policy is made payable to the person whose life is insured if the beneficiary or assignee shall predecease such person, and such proceeds and avails shall be exempt from all liability for any debt of the beneficiary existing at the time the policy is made available for his use: provided, that subject to the statute of limitations, the amount of any premiums for such insurance paid with intent to defraud creditors, with interest thereon, shall inure to their benefit from the proceeds of the policy; but the insurer issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless, before such payment, the insurer shall have received written notice at its home office, by or in behalf of a creditor, of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specification of the amount claimed.

(2) For the purposes of subsection (1) above, a policy shall also be deemed to be payable to a person other than the insured if and to the extent that a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by such clause.

(3) This section shall not be affected by the terms of [section 15-6-107, Idaho Code](#).

History.

1961, ch. 330, § 425, p. 645; am. 2003, ch. 248, § 1, p. 639.

CASE NOTES

Beneficiaries.

Bankruptcy debtors properly claimed an exemption in life insurance proceeds received by one debtor as a beneficiary, since proceeds of the life insurance policy were exempt from the claims of the debtor's creditors existing at the time the proceeds were made available for the debtor's use. *In re Gutke*, 528 B.R. 798 (Bankr. D. Idaho 2015).

§ 41-1834. Exemption of proceeds — Disability insurance. — Except as may otherwise be expressly provided by the policy or contract, the proceeds or avails of all contracts of disability insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts heretofore or hereafter effected shall be exempt from all liability for any debt of the insured, and from any debt of the beneficiary existing at the time the proceeds are made available for his use.

This section shall not be affected by the terms of [section 15-6-107, Idaho Code](#).

History.

1961, ch. 330, § 426, p. 645; am. 2003, ch. 248, § 2, p. 639.

§ 41-1835. Exemption of proceeds — Group insurance. — (1) A policy of group life insurance or group disability insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder, shall not be liable, either before or after payment, to be applied by any legal or equitable process to pay any debt or liability of such insured individual or his beneficiary or of any other person having a right under the policy. The proceeds thereof, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, shall not constitute a part of the estate of the individual insured for the payment of his debts.

(2) This section shall not apply to group insurance issued pursuant to this code to a creditor covering his debtors, to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.

(3) This section shall not be affected by the terms of [section 15-6-107, Idaho Code](#).

History.

1961, ch. 330, § 427, p. 645; am. 2003, ch. 248, § 3, p. 639.

§ 41-1836. Exemption of proceeds — Annuity contracts — Assignability of rights. — (1) The benefits, rights, privileges and options which under any annuity contract heretofore or hereafter issued are due or prospectively due the annuitant, shall not be subject to execution nor shall the annuitant be compelled to exercise any such rights, powers, or options, nor shall creditors be allowed to interfere with or terminate the contract, except:

(a) As to amounts paid for or as premium on any such annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice at its home office prior to the making of the payments to the annuitant out of which the creditor seeks to recover. Any such notice shall specify the amount claimed or such facts as will enable the insurer to ascertain such amount, and shall set forth such facts as will enable the insurer to ascertain the annuity contract, the annuitant and the payments sought to be avoided on the ground of fraud.

(b) The total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity contracts under which he is an annuitant, shall not at any time exceed one thousand two hundred fifty dollars (\$1,250) per month for the length of time represented by such installments, and that such periodic payments in excess of one thousand two hundred fifty dollars (\$1,250) per month shall be subject to garnishee execution to the same extent as are wages and salaries.

(c) If the total benefits presently due and payable to any annuitant under all annuity contracts under which he is an annuitant, shall at any time exceed payment at the rate of one thousand two hundred fifty dollars (\$1,250) per month, then the court may order such annuitant to pay to a judgment creditor or apply on the judgment, in installments, such portion of such excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and his family, if dependent upon him, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(d) As to any deferred annuity contract having a cash surrender provision and from which no periodic payments are being made, the cash surrender value of the deferred annuity contract, not to exceed premiums paid into the deferred annuity contract within six (6) months prior to the filing of a bankruptcy petition, as defined in [11 U.S.C. section 101](#), or the date of attachment or levy on execution, as defined in [section 11-201, Idaho Code](#), whichever is applicable.

(2) If the contract so provides, the benefits, rights, privileges or options accruing under such contract to a beneficiary or assignee shall not be transferable nor subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained herein for the annuitant, shall apply with respect to such beneficiary or assignee.

(3) An annuity contract within the meaning of this section shall be any obligation to pay certain sums at stated times, during life or lives, or for a specified term or terms, issued for a valuable consideration, regardless of whether or not such sums are payable to one (1) or more persons, jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives, or for a specified term or terms.

(4) This section shall not be affected by the terms of [section 15-6-107, Idaho Code](#).

History.

1961, ch. 330, § 428, p. 645; am. 2001, ch. 285, § 1, p. 1020; am. 2003, ch. 248, § 4, p. 639; am. 2013, ch. 246, § 1, p. 596.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 246, added paragraph (1)(d).

CASE NOTES

[Bankruptcy.](#)

[Exemption.](#)

Bankruptcy.

Debtors were allowed to claim an exemption with respect to an annuity, pursuant to paragraph (1)(b), where, although the funds used to purchase the annuity were derived from nonexempt sources, debtors acted in good faith in trying to settle claims against them and lacked fraudulent intent. *In re Hall*, 464 B.R. 896 (Bankr. D. Idaho 2012).

Exemption.

Under this section, annuity benefits that are due or prospectively due are exempt from the reach of the annuitant's creditors (as well as a bankruptcy trustee), but the exemption is limited to \$1,250 per month for any benefits presently due and payable to any annuitant periodically or at stated times. An annuitant may seek to protect more \$1,250 per month in benefit payments, but only upon a showing of need. The presumption is that annuity benefit payments to an annuitant in excess of the statutory cap are not exempt and are vulnerable to the claims of the annuitant's creditors. *In re Wiley*, 469 B.R. 326 (Bankr. D. Idaho 2012).

For the exemption of paragraph (1)(b) to apply in a bankruptcy proceeding, some sort of annuity benefit payment election must have been made by the debtor as of the date the bankruptcy petition is filed. Were this not the case, the mathematical calculation required by this section would be impossible. *In re Wiley*, 469 B.R. 326 (Bankr. D. Idaho 2012).

Because debtors did not show that the wife was a dependent of her former spouse, they could not exempt annuity payments under § 11-604(1) (c). However, the annuity payments were exempt under this section, but debtors were held to the statutory cap of \$1,250 per month because their income was likely to exceed their expenses. *In re Baldwin*, 2012 Bankr. LEXIS 5376 (Bankr. D. Idaho Nov. 13, 2012).

Before filing for bankruptcy, debtors purchased annuity contracts which contained options for payment of the annuity in different ways, including a lump sum payment; at the time the case was heard, no option had been exercised. The contracts were exempt annuities for bankruptcy purposes, even though exercise of one or more of the options might diminish or remove the exemption, and the bankruptcy court could not force a debtor to

exercise an option. *Aden v. Gugino (In re Aden)*, 484 B.R. 379 (D. Idaho 2012).

Debtors' transfer of funds to purchase annuity immediately prior to their bankruptcy filing constituted a transfer with intent to defraud creditors, warranting upholding the trustee's objection to the debtors' claimed exemption for the annuity. *In re Preuit*, 2013 Bankr. LEXIS 2331 (Bankr. D. Idaho June 7, 2013).

§ 41-1837. Return of unearned premiums on destruction of property.

— In the event of the total destruction of any insured property, on which the total amount of loss or agreed loss shall be less than the total amount insured thereon, the insurer or insurers shall return to the insured the unearned insurance premium for the excess of the insurance over the appraised or agreed loss, to be paid at the same time and in the same manner as the loss shall be paid.

History.

1961, ch. 330, § 429, p. 645.

§ 41-1838. Venue of suits against insurers. — Suit upon causes of action arising within this state against an insurer upon an insurance contract shall be brought in the county where the cause of action arose or in the county where the policy holder instituting such action resides.

History.

1961, ch. 330, § 430, p. 645.

STATUTORY NOTES

Cross References.

Unauthorized surplus line insurers, venue, § 41-1231.

CASE NOTES

Decisions Under Prior Law [Foreign surety company.](#)

[Service of process.](#)

[Foreign Surety Company.](#)

Foreign surety company was a foreign “insurance” company within statutory definition. [American Surety Co. v. Ada County Dist. Court](#), 43 Idaho 589, 254 P. 515 (1927).

[Service of Process.](#)

Insurance companies were required to designate the commissioner of finance as their agent for service of process. [Union Cent. Life Ins. Co. v. Rahn](#), 63 Idaho 243, 118 P.2d 717 (1941).

§ 41-1839. Allowance of attorney's fees in suits against or in arbitration with insurers. — (1) Any insurer issuing any policy, certificate or contract of insurance, surety, guaranty or indemnity of any kind or nature whatsoever that fails to pay a person entitled thereto within thirty (30) days after proof of loss has been furnished as provided in such policy, certificate or contract, or to pay to the person entitled thereto within sixty (60) days if the proof of loss pertains to uninsured motorist or underinsured motorist coverage benefits, the amount that person is justly due under such policy, certificate or contract shall in any action thereafter commenced against the insurer in any court in this state, or in any arbitration for recovery under the terms of the policy, certificate or contract, pay such further amount as the court shall adjudge reasonable as attorney's fees in such action or arbitration.

(2) In any such action or arbitration, if it is alleged that before the commencement thereof, a tender of the full amount justly due was made to the person entitled thereto, and such amount is thereupon deposited in the court, and if the allegation is found to be true, or if it is determined in such action or arbitration that no amount is justly due, then no such attorney's fees may be recovered.

(3) This section shall not apply as to actions under the worker's compensation law, title 72, Idaho Code. This section shall not apply to actions or arbitrations against surety insurers by creditors of or claimants against a principal and arising out of a surety or guaranty contract issued by the insurer as to such principal, unless such creditors or claimants shall have notified the surety of their claim, in writing, at least sixty (60) days prior to such action or arbitration against the surety. The surety shall be authorized to determine what portion or amount of such claim is justly due the creditor or claimant and payment or tender of the amount so determined by the surety shall not be deemed a volunteer payment and shall not prejudice any right of the surety to indemnification and/or subrogation so long as such determination and payment by the surety be made in good faith. Nor shall this section apply to actions or arbitrations against fidelity insurers by claimants against a principal and arising out of a fidelity contract or policy issued by the insurer as to such principal unless the liability of the principal

has been acknowledged by him in writing or otherwise established by judgment of a court of competent jurisdiction.

(4) Notwithstanding any other provision of statute to the contrary, this section and [section 12-123, Idaho Code](#), shall provide the exclusive remedy for the award of statutory attorney's fees in all actions or arbitrations between insureds and insurers involving disputes arising under policies of insurance. Provided, attorney's fees may be awarded by the court when it finds, from the facts presented to it that a case was brought, pursued or defended frivolously, unreasonably or without foundation. [Section 12-120, Idaho Code](#), shall not apply to any actions or arbitrations between insureds and insurers involving disputes arising under any policy of insurance.

History.

1961, ch. 330, § 431, p. 645; am. 1965, ch. 105, § 1, p. 191; am. 1996, ch. 384, § 1, p. 1307; am. 1996, ch. 385, § 1, p. 1308; am. 2010, ch. 251, § 1, p. 641; am. 2013, ch. 257, § 1, p. 633.

STATUTORY NOTES

Cross References.

Unauthorized insurer, attorney's fees, § 41-1209.

Amendments.

The 2010 amendment, by ch. 251, in the section heading, inserted "or in arbitration with"; throughout the section, inserted "or arbitration" or similar language; and in subsection (3), deleted "which are subject to" following "worker's compensation law," and substituted "title 72" for "section 72-611."

The 2013 amendment, by ch. 257, in subsection (1), substituted "that fails to pay a person entitled thereto within" for "which shall fail for a period of", inserted "or" following "certificate or contract", inserted "within sixty (60) days if the proof of loss pertains to uninsured motorist or underinsured motorist coverage benefits", inserted "that person is" following "the amount", and substituted "thereafter commenced" for "thereafter brought."

Effective Dates.

Section 2 of S.L. 1965, ch. 105 declared an emergency. Approved March 8, 1965.

Section 2 of S.L. 1996, ch. 384 declared an emergency and provided that the act shall apply to all cases pending at the time of its passage and approval. Approved March 20, 1996.

Section 2 of S.L. 1996, ch. 385 declared an emergency and provided that the act shall apply to all cases pending at the time of its passage and approval. Approved March 20, 1996.

CASE NOTES

Adjudication of no liability.

Amount justly due.

Amount of verdict.

Arbitration.

Attorney fees.

— Additional insured.

— Amount.

— Appeal not frivolous.

— Applicable law.

— Contingent.

— Discretion of court.

— Final judgment.

— In actions for declaratory judgment.

— On appeal.

Conflict of laws.

Discretion of court.

Duty of claimant.

In general.

- In relation to punitive damages.
- Notice to surety.
- On appeal.
- Person entitled to amount justly due.
- Reimbursement requirement.
- Subrogee.

Interstate commerce.

Justifiable delay in payment.

Justly due.

“Miller act” suit.

Nonprofit service corporation.

Prevailing party.

Proof of loss.

Punitive damages.

Purpose.

Refusal of insurer to defend insured.

Refusal to pay.

Summary judgment inapplicable.

Surety.

Time limitation.

Voluntary payment.

Waiver of proof of loss requirement.

Adjudication of No Liability.

This section was inapplicable where it had been adjudicated that no amount was justly due the insured under the terms of policy coverage. *Foremost Ins. Co. v. Putzier*, 100 Idaho 883, 606 P.2d 987 (1980).

Amount Justly Due.

Merely offering the amount justly due does not constitute either paying it to the person entitled thereto or depositing it in the court. Likewise, sending the person entitled thereto a warrant or check with instructions not to negotiate the warrant or check does not constitute payment until there is permission to negotiate it. *Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland)*, 153 Idaho 94, 279 P.3d 80 (2012).

Amount of Verdict.

The insured need not obtain a verdict for the full amount requested in order to be awarded reasonable attorney fees, but only a verdict for an amount greater than that tendered by the insurer. *Slaathaug v. Allstate Ins. Co.*, 132 Idaho 705, 979 P.2d 107 (1999).

Arbitration.

Once the trial court denied attorney fees, the insureds were required to appeal the final judgment within 42 days; when they failed to do so, the court lost jurisdiction to change its original decision despite the decision by the Idaho supreme court allowing attorney fees where an arbitrator rules in the insureds' favor. *Scaggs v. Mut. of Enumclaw Ins. Co.*, 141 Idaho 114, 106 P.3d 440 (2005).

This section only permits insureds to collect attorney fees incurred in a civil "action" to recover under an insurance policy. there is no language indicating that this section is meant to imply a provision for arbitration attorney fees into every insurance policy. *The Grease Spot, Inc. v. Harnes*, 148 Idaho 582, 226 P.3d 524 (2010) (see 2010 amendment).

Following the 2010 amendment of this section, an insured, who filed a petition to confirm an arbitration award, is entitled to an award for any attorney's fees incurred between the July 1 effective date of the amendment and the filing of the petition. *Ferrell v. United Fin. Cas. Co.*, 155 Idaho 85, 305 P.3d 529 (2013).

Attorney Fees.

Where the assured recovered less than he claimed, but the insurer had made no tender of the amount found due, the assured was entitled to attorney fees. *Halliday v. Farmers Ins. Exch.*, 89 Idaho 293, 404 P.2d 634 (1965).

An administrator of the estate of a deceased additional insured who recovers judgment against insurer for funeral expenses of additional insured is entitled to recover attorney fees from insurer. *Pendlebury v. Western Cas. & Sur. Co.*, 89 Idaho 456, 406 P.2d 129 (1965).

Where suit is brought against the insured as owner and against additional insured's administrator as operator and, because of possible conflict of interest, insurer asks administrator of additional insured to employ independent defense counsel, insurer is liable to such administrator for the fees of such counsel. *Pendlebury v. Western Cas. & Sur. Co.*, 89 Idaho 456, 406 P.2d 129 (1965).

Livestock producer who brought suit against registered livestock dealer's surety on dealer's bond to recover amount of unpaid drafts drawn by dealer against his principal, a purchaser from producer, was properly awarded attorney fees, where surety's rejection of producer's claim was not preponderately reasonable, though it was based upon some tenable grounds. *United States Fid. & Guar. Co. v. Clover Creek Cattle Co.*, 92 Idaho 889, 452 P.2d 993 (1969).

Where, in action on policy of life insurance the applicable statute of limitations was five (5) years on the breached contract, the award of attorney fees is proper under this section as part of the relief which may be accorded a claimant in such action. *Dunford v. United of Omaha*, 95 Idaho 282, 506 P.2d 1355 (1973).

Where insurer notified insured that it would not cover any award of punitive damages such refusal constituted a breach of the insurance contract and insured was entitled to recover the reasonable attorneys' fees paid to attorneys he was required to hire after insurer's breach of contract. *Abbie Uriguen Oldsmobile Buick, Inc. v. United States Fire Ins. Co.*, 95 Idaho 501, 511 P.2d 783 (1973).

In suit for destruction of mobile home where insurer tendered the full amount of its coverage into court, it was not obligated to pay attorney fees

or interest. *Stein-McMurray Ins. Inc. v. Highlands Ins. Co.*, 95 Idaho 818, 520 P.2d 865 (1974).

Anyone having a claim under an insurance policy and furnishing proof of loss may recover attorney fees against insurer in an action on the policy if the amount finally recovered exceeds the amount tendered by insurer before the start of the action. *Associates Disct. Corp. v. Yosemite Ins. Co.*, 96 Idaho 249, 526 P.2d 854 (1973).

In an action brought by a buyer against his surety for the loss of machines subsequent to their purchase at an execution sale, buyer was not entitled to attorney fees since he made no showing that he had complied with provisions of this section. *Garren v. Butigan*, 96 Idaho 906, 539 P.2d 259 (1975).

The amount of attorney's fees to be awarded is that sum which the trial court in its discretion determines to be reasonable. *Smith v. Great Basin Grain Co.*, 98 Idaho 266, 561 P.2d 1299 (1977).

There is no requirement that the amount of attorney's fees awarded bear a reasonable relationship to the amount of the judgment. *Smith v. Great Basin Grain Co.*, 98 Idaho 266, 561 P.2d 1299 (1977).

Where plaintiff homeowners submitted proof of loss to insurer several days after fire destroyed their home, but the insurer made no tender of payment prior to the filing of plaintiff's complaint because of a dispute over title to the home, the plaintiffs were entitled to attorney's fees. *Continental Re-Insurance Co. v. Spanton*, 667 F.2d 1289 (9th Cir. 1982).

The district court did not err by awarding attorney fees where the insurer brought a declaratory judgment action as a plaintiff. *Unigard Ins. Co. v. United States Fid. & Guar. Co.*, 111 Idaho 891, 728 P.2d 780 (Ct. App. 1986).

The district court did not err by granting attorney fees under this section, even though the insured was represented by an attorney who also represented, and presumably was being paid by another insurance company. *Unigard Ins. Co. v. United States Fid. & Guar. Co.*, 111 Idaho 891, 728 P.2d 780 (Ct. App. 1986).

This section limits awards of attorney fees to those instances where: (1) the insured has provided a proof of loss as required by the insurance policy;

(2) the insurance company fails to pay an amount justly due under the policy within 30 days of such proof of loss; and (3) the insured thereafter is compelled to bring suit to recover for his loss. *Reynolds v. American Hdwe. Mut. Ins. Co.*, 115 Idaho 362, 766 P.2d 1243 (1988).

If the insurance company tenders an amount that is agreeable to the plaintiff, the plaintiff will accept and that will be the end of it and the question of what amount is just only arises when the plaintiff and the insurance company cannot agree; if the plaintiff chooses to pursue the matter, the matter goes to court and the jury determines what amount is justly due and if the insurance company was right, no attorney fees will be charged but if the plaintiff was right, attorney fees will be charged. Both sides realize this when they go to court and both sides assume an equal and inevitable risk. *Brinkman v. Aid Ins. Co.*, 115 Idaho 346, 766 P.2d 1227 (1988), overruled on other grounds, *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006).

This section limits awards of attorney fees to those instances where: 1) the insured has provided a proof of loss as required by the insurance policy; 2) the insurance company fails to pay an amount justly due under the policy within 30 days of such proof of loss; and 3) the insured thereafter is compelled to bring suit to recover for his loss. *Emery v. United Pac. Ins. Co.*, 120 Idaho 244, 815 P.2d 442 (1991), overruled on other grounds, *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006), and overruled on other grounds, *The Grease Spot, Inc. v. Harnes*, 148 Idaho 582, 226 P.3d 524 (2010).

Where an insured is required and compelled to file a lawsuit by reason of an insurer's refusal to pay in order to recover under her insurance contract, it is implicit in this section that the court shall adjudge a reasonable award of attorney fees against the insurer; the attorney fee authorized by this section is not a penalty, but an additional sum rendered as just compensation. *Emery v. United Pac. Ins. Co.*, 120 Idaho 244, 815 P.2d 442 (1991), overruled on other grounds, *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006), and overruled on other grounds, *The Grease Spot, Inc. v. Harnes*, 148 Idaho 582, 226 P.3d 524 (2010).

Rental agency's insurer was under a duty, as driver's insurer, to pay the debts incurred by driver as a result of the accident, and where driver was

also covered under parent's automobile policy, driver had a right, as an insured under parent's policy, to require parent's insurer to pay its share of liability for driver's accident, and if it became necessary to secure such payment from parent's insurer, driver would have been entitled to recover attorney fees. *Empire Fire & Marine Ins. Co. v. North Pac. Ins. Co.*, 127 Idaho 716, 905 P.2d 1025 (1995).

Legislature did not, through the enactment of this section, grant parties an independent right of action simply for the recovery of attorney fees incurred in arbitration, when such fees clearly cannot be awarded as part of the arbitration. *Wolfe v. Farm Bureau Ins. Co.*, 128 Idaho 398, 913 P.2d 1168 (1996), overruled on other grounds, *Jackson Hop, LLC v. Farm Bureau Mut. Ins. Co.*, 158 Idaho 894, 354 P.3d 456 (2015).

Attorney fees may be awarded to an insured under this section only when the insured had no other option other than to file suit against his or her insurer in order to recover his or her loss. Thus, plaintiff's, whose arbitration award provided amount justly due to her for uninsured motor insurance, could not recover attorney fees in subsequent suit. She was neither compelled nor required to bring the suit to recover her losses. *Anderson v. Farmers Ins. Co.*, 130 Idaho 755, 947 P.2d 1003 (1997).

Where the plaintiff neither alleged nor provided any evidence that the defendant failed to pay her medical expenses and property damage within thirty days of her proof of loss, she did not satisfy the requirements for an award of attorney fees under this section. *Smith v. USAA Property & Cas. Ins.*, 132 Idaho 466, 974 P.2d 1095 (1999).

Attorney fees were not awarded to the defendants on appeal where the court concluded that an insurance company had no obligation to pay under its contract. *Mutual of Enumclaw Ins. Co. v. Pedersen*, 133 Idaho 135, 983 P.2d 208 (1999).

Insurer did not tender an amount justly due under the policy within thirty days of the proof of loss, therefore, reasonable attorney fees had to be awarded to the worker pursuant to this section; on remand, the district court had to determine a reasonable amount of attorney fees after the case was fully resolved. *Am. Foreign Ins. Co. v. Reichert*, 140 Idaho 394, 94 P.3d 699 (2004).

Trial court did not err by denying the insured's request for an award of his attorney fees as the prevailing party in an action with the insurer because the insured was unable to recover his attorney fees because the insurer never wrongly refused to pay an amount justly due to him under this section. [Certain Underwriters at Lloyds v. Wolleson](#), 141 Idaho 740, 118 P.3d 72 (2005).

Denial of attorney fees to the insureds in their action against the insurer after the insurer refused coverage for mold was appropriate because the insurer did not fail to pay an amount "justly due." The mold coverage was excluded under the insureds' homeowner's policy. [Melichar v. State Farm Fire and Cas. Co.](#), 143 Idaho 716, 152 P.3d 587 (2007).

Denial of attorney fees to the insurer in the insureds' action against the insurer after the insurer refused coverage for mold was appropriate because nothing in the record suggested that the insureds' appeal was frivolous. [Melichar v. State Farm Fire and Cas. Co.](#), 143 Idaho 716, 152 P.3d 587 (2007).

Where appellant insured's suit against respondent insurance company for breach of an insurance contract and declaratory relief was dismissed and the supreme court upheld the decision, although the insurance company prevailed on appeal, subsection (4) of this section precluded an award of attorney fees. [Villa Highlands, LLC v. Western Cmty. Ins. Co.](#), 148 Idaho 598, 226 P.3d 540 (2010).

This section and § 12-123 are the exclusive remedies for obtaining attorney fees in insurance disputes. The award of fees was proper where the insured never raised any triable issues of fact and did not attempt to offer any factual evidence to support his claims that the title company acted without diligence or in bad faith when it sought to obtain for him an ownership interest in the access road, even though he demanded that the title company do something to ensure he had an easement there. [Mortensen v. Stewart Title Guar. Co.](#), 149 Idaho 437, 235 P.3d 387 (2010).

In a suit stemming from an insurer's bad faith failure to pay medical bills of its innocent insureds who were injured in an automobile collision, the trial court erred in awarding attorney fees under subsection (1) of this section based upon the insurer's failure to pay for an insured's future medical expenses or general damages because the insureds never submitted

a proof of loss for such damages and, thus, failed to meet the condition precedent for an award of attorney fees for recovering those damages. Because the insureds only submitted claims for past medical services received and did not submit a claim for future medical expenses, the insurer did not act in bad faith in failing to pay future medical expenses. *Weinstein v. Prudential Prop. & Cas. Ins. Co.*, 149 Idaho 299, 233 P.3d 1221 (2010).

Attorney's fees were awarded to the child under subsection (1), where there was no doubt that the insurer had knowledge for quite some time of the fact that child's damages exceeded the limits of both of its policies and yet failed to pay under those policies. *Gearhart v. Mut. of Enumclaw Ins. Co.*, 160 Idaho 664, 378 P.3d 454 (2016).

District court's award of attorney fees to an insurer was affirmed because the deceased insured's parents failed to raise the applicable standard of review or make a cogent argument showing that the district court abused its discretion in granting a summary judgment against the insured's parents. *Estate of Ekic v. GEICO Indem. Co.*, 163 Idaho 895, 422 P.3d 1101 (2018).

— Additional Insured.

Any person, including an additional insured, who has a claim under an insurance contract may recover attorney fees under this section. *Bonner County v. Panhandle Rodeo Ass'n*, 101 Idaho 772, 620 P.2d 1102 (1980).

Where an insurer refused to compensate the estate of the deceased automobile accident victim but instead brought an unsuccessful declaratory judgment action seeking an order declaring that the insurer had no duty to defend or identify the estate of the deceased, who had been listed as an additional insured on his mother's automobile insurance policy, the deceased's estate was entitled to recover its reasonable attorney's fees and costs in defending the action. *Automobile Club Ins. Co. v. Tyrer*, 560 F. Supp. 755 (D. Idaho 1983), *aff'd*, 734 F.2d 20 (9th Cir. 1984).

— Amount.

Upon affirming a trial court judgment for \$507.95 under the upset clause of an automobile policy, the supreme court allowed \$500 as the insured's attorney fees on the appeal. *Dillehay v. Hartford Fire Ins. Co.*, 91 Idaho 360, 421 P.2d 155 (1966).

“Amount justly due” means an amount ultimately determined by the jury. *Brinkman v. Aid Ins. Co.*, 115 Idaho 346, 766 P.2d 1227 (1988), overruled on other grounds, *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006).

Where, as to the documentation of the amount of attorney fees awarded, the trial court had a memorandum of costs submitted by plaintiffs’ attorney that included the number of hours expended by the attorney and an associate and the hourly rate used to calculate the total fee, while there was evidence offered by defendant insurance company that hourly rate for the plaintiffs’ attorney exceeded the usual rate in the local area, the trial court considered the factors listed in *Idaho R. Civ. P. 54(e)(3)*, especially the expertise of the attorney in prosecuting claims against insurance companies, and the trial court was within its discretion in the award of attorney fees. *Garnett v. Transamerica Ins. Servs.*, 118 Idaho 769, 800 P.2d 656 (1990).

— Appeal Not Frivolous.

Although a court may properly award attorney fees under subsection (4) of this section regardless of any pending proceedings in the case, where the defendant’s arguments on appeal were not brought and pursued frivolously or without foundation, such an award was not appropriate. *Slaathaug v. Allstate Ins. Co.*, 132 Idaho 705, 979 P.2d 107 (1999).

Insurer sought attorney fees in declaratory judgment matter brought by the insurer to determine its duty to defend an investment company, its insured, in the underlying suit. The argument advanced by the investment company that the complaint should be broadly construed to encompass non-excluded claims was not frivolous. *AMCO Ins. Co. v. Tri-Spur Inv. Co.*, 140 Idaho 733, 101 P.3d 226 (2004).

Subsection (4) authorizes an award of attorney fees if an appeal is brought frivolously: such as when an appellant is merely asking the supreme court to second-guess the district court’s ruling, despite unambiguous controlling language in the insurance policy. *Mortensen v. Stewart Title Guar. Co.*, 149 Idaho 437, 235 P.3d 387 (2010).

Insurer was not entitled to attorney fees, because the insured presented a legitimate question of law as to how “surface water” should be interpreted

under the terms of his contract [Rizzo v. State Farm Ins. Co., 155 Idaho 75, 305 P.3d 519 \(2013\)](#).

— Applicable Law.

Because this section was amended to include subsection (4) which excludes award of attorney fees under § 12-120 in actions between insureds and insurers involving disputes arising under any policy of insurance, and the legislature expressly stated its intent that this act apply to all cases pending at the time of passage and approval, district court's award of attorney fees in suit brought against insurer by seed cooperative was reversed and request for fees on appeal denied to seed cooperative and umbrella insurer. [Union Whse. & Supply Co. v. Illinois R.B. Jones, Inc., 128 Idaho 660, 917 P.2d 1300 \(1996\)](#).

In action for attorney's fees pursuant to this section where the most significant relationships of the case were attached to the state of Washington: the contract was negotiated and formed in Washington; the plaintiffs were residents of Washington at the time the contract was formed and at the time of the accident; when the accident occurred it was clear that Washington law would have applied to the issues in the case; Idaho's contact with the case came about subsequent to the time when the plaintiff's rights under the contract were fixed; therefore the law of Washington applied to the determination of whether the plaintiff's were entitled to attorney's fees. [Barber v. State Farm Mut. Auto. Ins. Co., 129 Idaho 677, 931 P.2d 1195 \(1997\)](#).

Even though a complaint against an insurer was not amended to assert the plaintiff's status as an assignee of the insured until after the enactment of an amendment to subsection (4) of this section, the fact that the legislature had expressly stated that the amendment was retroactive, applying to all cases pending at the time of its passage and approval, meant that the mandatory prevailing party fee award applicable under § 12-120(3) to commercial transaction disputes would be barred in a case where the assignee could be characterized as an insured. [J.R. Simplot Co. v. Western Heritage Ins. Co., 132 Idaho 582, 977 P.2d 196 \(1999\)](#).

Where an insured effectively assigned to the plaintiff his right as an insured to collect money due under a policy and to sue the defendant insurance company for breach, the plaintiff stood in the shoes of the insured

in a dispute arising under an insurance policy, and the trial court erred in awarding attorney fees under § 12-120(3). *J.R. Simplot Co. v. Western Heritage Ins. Co.*, 132 Idaho 582, 977 P.2d 196 (1999).

Before an insured could recover attorney fees under this section, he had to show that: (1) he had provided proof of loss as required by the insurance policy; and (2) the insurance company failed to pay an amount justly due under the policy within 30 days of such proof of loss, but he was not required to show the insurer's failure to pay compelled him to bring suit against the insurer in order to recover for the loss. *Martin v. State Farm Mut. Auto. Ins. Co.*, 138 Idaho 244, 61 P.3d 601 (2002).

“An amount justly due,” as used in this section, is not limited to an amount determined by a jury, but was interpreted to include an amount found owing by the arbitrators in an arbitration proceeding. *Martin v. State Farm Mut. Auto. Ins. Co.*, 138 Idaho 244, 61 P.3d 601 (2002).

In an interlocutory appeal over whether an innocent co-insured was entitled to recover after an act of arson by the other insured, nothing in the record showed that the insurer failed to pay the loss, or that the innocent insured had been compelled to bring suit to recover the loss; consequently, while the innocent insured was not entitled to attorney fees pursuant to this section following the interlocutory appeal, the innocent insured may have been entitled to attorney fees at a later date. *Trinity Universal Ins. Co. v. Kirsling*, 139 Idaho 89, 73 P.3d 102 (2003).

Insured's suit for alleged breach of statutory duties incorporated into an insurance agreement does not constitute a dispute “arising under policies of insurance” for purposes of applying subsection (4). *Hayden Lake Fire Prot. Dist. v. Alcorn*, 141 Idaho 307, 109 P.3d 161 (2005), overruled on other grounds, *City of Osburn v. Randel*, 152 Idaho 906, 277 P.3d 353 (2012).

For subsection (4) to apply, the cause of action had to be a policy-based claim, and the common fund was a claim in equity; it was therefore not a policy-based claim and the insurer was not entitled to an award of attorney fees. *Lopez v. Farm Bureau Mut. Ins. Co.*, 148 Idaho 515, 224 P.3d 1104 (2010).

— **Contingent.**

In suit by injured driver against insurance company, trial court did not abuse its discretion by awarding \$20,000 in attorney fees pursuant to contingent fee agreement. Contingent fee agreement was not unreasonable simply because attorney would recover more than he would have under an hourly fee contract. *Parsons v. Mutual of Enumclaw Ins. Co.*, 143 Idaho 743, 152 P.3d 614 (2007).

— Discretion of Court.

Trial court abused its discretion in awarding attorney fees in an alleged fraud, breach of contract, and misrepresentation suit brought against an insurer. Although the insured's attorney withheld a letter showing that the insured had knowledge of the alleged fraud at an early date, the attorney had no duty to disclose the letter, and the matter was one of first impression and complex litigation. *McCorkle v. Northwestern Mut. Life Ins. Co.*, 141 Idaho 550, 112 P.3d 838 (Ct. App. 2005).

— Final Judgment.

In wrongful death action since no amount was justly due unless or until the district court entered judgment for plaintiffs, where motion for new trial was pending no allowance of attorney's fees could be made prior to final judgment, for this section does not compel further payment of attorneys' fees if plaintiffs' action fails. *Dawson v. Olson*, 94 Idaho 636, 496 P.2d 97 (1972).

Where a new trial had been ordered, the trial court properly deferred any decision as to attorney fees until the lawsuit was fully concluded. *Slaathaug v. Allstate Ins. Co.*, 132 Idaho 705, 979 P.2d 107 (1999).

After remanding the case for arbitration, a court declined to award an insured appellate attorney fees where the substantive claim of the dispute, i.e., the amount owed to the insured, if any, under an insurance policy had not been resolved. *Deeds v. Regence Blueshield of Idaho*, 143 Idaho 210, 141 P.3d 1079 (2006).

Because an appellate court decided to remand a matter, it was not yet decided if an insured was the prevailing party in his action against an insurer and was entitled to fees; thus, his request for fees was denied. However, if it were decided that the insured was entitled to fees below, then

he was entitled to fees for the appeal. [Arreguin v. Farmers Ins. Co.](#), 145 Idaho 459, 180 P.3d 498 (2008).

— In Actions for Declaratory Judgment.

A policy holder was entitled to recover attorney's fees in an action for declaratory judgment and also in the supreme court for successfully resisting the insurer's appeal from such declaratory judgment from workmen's [now worker's] compensation insurer who refused to defend and cover the policy holder before the industrial accident board against a claim filed by an injured employee on the ground that the policy holder had no compensation insurance with such insurer. [Martin v. Argonaut Ins. Co.](#), 91 Idaho 885, 434 P.2d 103 (1967).

Insured was not entitled to attorney fees in a declaratory relief action brought by the insurer to determine coverage, where the insurer provided a defense to the claim against the insured and the insured failed to provide evidence of an amount "unjustly due." [Northland Ins. Co. v. Boise's Best Autos & Repairs](#), 131 Idaho 432, 958 P.2d 589 (1998).

Where an insured was the prevailing party in a declaratory judgment action brought by the insurer, he was entitled to attorney fees. [Northland Ins. Co. v. Boise's Best Autos & Repairs](#), 132 Idaho 228, 970 P.2d 21 (Ct. App. 1997).

Because insureds were not entitled to an award of attorney fees on an equitable basis, but were limited to exclusive statutory provisions regarding insurance coverage disputes, they were precluded from seeking an award for the cost of defending insurer's declaratory judgment suit under general fee statutes or the fee provisions of the uniform declaratory judgment statute. [Allstate Ins. Co. v. Mocaby](#), 133 Idaho 593, 990 P.2d 1204 (1999).

Attorney fees against an insurer were not appropriate where the company reasonably believed that the policy provided a basis for noncoverage, since their action in filing a declaratory judgment action could not be characterized as frivolous or unreasonable. [Allstate Ins. Co. v. Mocaby](#), 133 Idaho 593, 990 P.2d 1204 (1999).

— On Appeal.

Where an insured did not prevail on appeal in her action against her insurer, she was not entitled to attorney's fees on appeal. [Lovey v. Regence](#)

Blueshield of Idaho, 139 Idaho 37, 72 P.3d 877 (2003).

Insurance coverage case regarding an innocent co-insured, presented novel matters of law not previously decided by the Idaho supreme court, and therefore the supreme court denied the innocent insured's request for attorney fees pursuant to this section. *Trinity Universal Ins. Co. v. Kirsling*, 139 Idaho 89, 73 P.3d 102 (2003).

Conflict of Laws.

This section, and not Florida law, applied to an action under a self-insurance contract of a motor carrier for damage in transit of household goods carried from Florida to Idaho by the carrier under a contract made in Florida, with the insurance premium and freight charges paid at the Idaho destination, after which the damage was discovered. *Rungee v. Allied Van Lines*, 92 Idaho 718, 449 P.2d 378 (1968).

Discretion of Court.

Trial court did not abuse its discretion in refusing to indemnify insurer for attorney fees paid to insured motorist, where insurer refused to provide coverage to insured, who suffered injuries as a result of collision with an uninsured motorist, on the ground that the insured was responsible for her own injuries and where insured successfully brought action against insurer. *Griggs v. Safeco Ins. Co. of Am.*, 103 Idaho 790, 654 P.2d 378 (1982).

The party challenging the adequacy of an attorney fee award must show an abuse of discretion. *Manduca Datsun, Inc. v. Universal Underwriters Ins. Co.*, 106 Idaho 163, 676 P.2d 1274 (Ct. App. 1984).

The trial court has discretion, after considering the factors contained in Idaho R. Civ. P. 54(e)(3), to determine the amount of attorney fees that should be awarded pursuant to this section. *Young v. State Farm Mut. Auto. Ins. Co.*, 127 Idaho 122, 898 P.2d 53 (1995).

Duty of Claimant.

If a party claims this section provides authority for an award of attorney's fees, the party must cite to the section and, if applicable, the specific subsection, upon which the party relies or attorney's fees will not be awarded. *Rogers v. Household Life Ins. Co.*, 150 Idaho 735, 250 P.3d 786 (2011).

In General.

This section applies to an action against the surety for a bond warehouseman pursuant to § 69-209. *Smith v. Great Basin Grain Co.*, 98 Idaho 266, 561 P.2d 1299 (1977).

Under § 7-910, it is beyond the scope of an arbitrator's powers to award attorney fees to one of the parties absent a contractual agreement to do so. However, that limitation upon an arbitrator does not extend to the authority of the district court to award attorney fees pursuant to this section. *Emery v. United Pac. Ins. Co.*, 120 Idaho 244, 815 P.2d 442 (1991), overruled on other grounds, *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006), and overruled on other grounds, *The Grease Spot, Inc. v. Harnes*, 148 Idaho 582, 226 P.3d 524 (2010).

An application seeking the confirmation of an arbitration award is not an action in court to recover attorney fees pursuant to this section. *Wolfe v. Farm Bureau Ins. Co.*, 128 Idaho 398, 913 P.2d 1168 (1996), overruled on other grounds, *Jackson Hop, LLC v. Farm Bureau Mut. Ins. Co.*, 158 Idaho 894, 354 P.3d 456 (2015).

The abuse of discretion standard is used to review the award of attorney fees under this section. *Vaught v. Dairyland Ins. Co.*, 131 Idaho 357, 956 P.2d 674 (1998).

Attorney fees were denied where the insureds did not have to bring suit to recover for their loss, because the attorney fee provision in subsection (1) applies only when the insured has provided proof of a covered loss, the insurer has failed to pay an amount justly due under the policy within 30 days of the proof of loss, and the insured is thereafter compelled to bring suit to recover for the loss. *Wensman v. Farmers Ins. Co.*, 134 Idaho 148, 997 P.2d 609 (2000).

— In Relation to Punitive Damages.

In a case involving a claim against an insurance company for failure to pay an amount due under a policy, attorney fees may be awarded under this section, unless the jury has been specifically instructed to include attorney fees in any award of punitive damages or unless the trial court concludes that the award of punitive damages was so disproportionate that it included

attorney fees. *Garnett v. Transamerica Ins. Servs.*, 118 Idaho 769, 800 P.2d 656 (1990).

— **Notice to Surety.**

Where motion by respondent for attorney fees on appeal contained no averment, supported by record, that the notice was given to the surety at least 60 days prior to the action, the motion was denied. *School Dist. No. 91, Bonneville County v. Taysom*, 94 Idaho 599, 495 P.2d 5 (1972).

— **On Appeal.**

In reversing two (2) portions of a judgment on cross-appeal and affirming another on appeal to the circuit court of appeals, the plaintiff-respondent's motion for attorney's fees was committed to the federal district court for determination. *United Pac. Ins. Co. v. Idaho First Nat'l Bank*, 378 F.2d 62 (9th Cir. 1967).

Where the insurer appealed from an award of attorney fees in the district court and the judgment of the district court was affirmed, the assured was entitled to additional attorney fees for services of his attorneys in the appeal. *Halliday v. Farmers Ins. Exch.*, 89 Idaho 293, 404 P.2d 634 (1965).

Attorneys' fee of \$750 was added by the supreme court to a trial court judgment of \$6,000 affirmed on appeal by the insurer on the issue of double indemnity for accidental death where the insurer contended death was by suicide. *Haman v. Prudential Ins. Co.*, 91 Idaho 19, 415 P.2d 305 (1966).

It was error to allow the insured, in an action for declaratory judgment as to the existence of insurance coverage, attorney fees incurred by the insured in defending an action which the insured refused to defend under the alleged policy. *Huppert v. Wolford*, 91 Idaho 249, 420 P.2d 11 (1966).

The supreme court could not pass upon the district court's award of attorney's fees where, because of errors, in the record, it was necessary to remand the cause for further proceedings. *Matthews v. New York Life Ins. Co.*, 92 Idaho 372, 443 P.2d 456 (1968).

On affirming a trial court judgment for \$10,833.57 for wind storm damage to the insured's potato cellar on the insurer's appeal on the issue as to whether damage resulted from a wind storm or from faulty construction,

the supreme court added \$1,000 as the insured's attorney fees on the appeal. *Stephens v. New Hampshire Ins. Co.*, 92 Idaho 537, 447 P.2d 14 (1968).

In the appeal from the judgment entered in plaintiff's suit to recover on an accident policy for loss of sight, where the trial court's judgment had included an award to plaintiff of attorney's fees in the amount of \$3,500, the award on appeal of an additional sum of \$2,500 for attorney's fees was reasonable where the jury's verdict and the judgment entered thereon was supported by direct substantive evidence that an accidental injury occurred to plaintiff's eye. *Erikson v. Nationwide Mut. Ins. Co.*, 97 Idaho 288, 543 P.2d 841 (1975).

Insurer was entitled to attorney's fees on appeal where the insurer paid the amount justly due within 30 days after receipt of each proof of loss, and the insureds' arguments were unreasonable and lacked foundation, the language in the policy was unambiguous, and the insurer, on numerous occasions, informed the insureds' of their options. *Parks v. Safeco Ins. Co.*, 160 Idaho 556, 376 P.3d 760 (2016).

— Person Entitled to Amount Justly Due.

Because subsection (1) of this section does not limit the award of attorney fees to an insured, but speaks of the person entitled to the amount justly due, credit union, as lienholder entitled to amount due on automobile loan because it did not receive actual notice of insurance cancellation before termination of endorsement, was entitled to attorney fees at all stages of the case. *Pocatello R.R. Fed. Credit Union v. Dairyland Ins. Co.*, 129 Idaho 444, 926 P.2d 628 (1996).

— Reimbursement Requirement.

If a defendant pays a plaintiff amounts the plaintiff has incurred as a result of the defendant's tortious action, and the plaintiff does not then seek to recover for those amounts at trial, the defendant is simply not entitled to credit: in other words, there can be no "requirement" for reimbursement where there is no recovery sought for the same expenses that were previously paid. *Beale v. Speck*, 127 Idaho 521, 903 P.2d 110 (Ct. App. 1995).

— Subrogee.

A subrogee standing in the shoes of the insured is entitled to recover attorney fees incurred to secure payment under the terms of the policy. *Empire Fire & Marine Ins. Co. v. North Pac. Ins. Co.*, 127 Idaho 716, 905 P.2d 1025 (1995).

Interstate Commerce.

An action on the self-insurance contract of a motor carrier transporting household goods from Florida to Idaho was an insurance action and not an action for damages or penalty and, therefore, was exempted from the federal preemption of the regulation of interstate transportation of goods by motor carrier and plaintiff was not precluded by such preemption from recovery of attorney's fees under this section. *Rungee v. Allied Van Lines*, 92 Idaho 718, 449 P.2d 378 (1968).

This section, not affecting the ground of recovery and imposing, not a penalty, but a compensatory allowance for the expense of employing an attorney, where the carrier unreasonably delays payment of a just demand and thereby renders a suit necessary, was not precluded by federal preemption of the regulation of interstate transportation of goods by motor carrier from application to an action on the self-insurance contract of a motor carrier carrying household goods from Florida to Idaho. *Rungee v. Allied Van Lines*, 92 Idaho 718, 449 P.2d 378 (1968).

Justifiable Delay in Payment.

Insureds were not entitled to recover attorney's fees from their insurer under an automobile liability policy where insureds' claim under the uninsured motorist clause as presented to the insurer did not specify the total amount due and the insurer refused to pay until the insureds recovered judgment against the uninsured motorist and then promptly tendered the full amount of such judgment. *Carter v. Cascade Ins. Co.*, 92 Idaho 136, 438 P.2d 566 (1968), overruled on other grounds, *Associates Disct. Corp. v. Yosemite Ins. Co.*, 96 Idaho 257, 526 P.2d 854 (1973).

Justly Due.

Under this section, no amount is "justly due" until facts substantially indicative of the uninsured motorist's liability are shown the insurer. *Jones v. State Farm Mut. Auto Ins. (In re Jones)*, 2009 Bankr. LEXIS 5520 (D. Idaho June 22, 2009).

“Miller Act” Suit.

Unless there is a separate state claim at the trial level attorneys’ fees are not available in a Miller Act (40 U.S.C. § 270a et seq.) suit even when state law provides for such an award. *United States ex rel. Leno v. Summit Constr. Co.*, 892 F.2d 788 (9th Cir. 1989).

Nonprofit Service Corporation.

This section, providing for an award of fees against an insurer, is not included among those sections applicable to nonprofit “service corporations.” *Howard v. Blue Cross of Idaho Health Serv., Inc.*, 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987) (decision prior to 1988 amendment of § 41-3434).

Prevailing Party.

In order to receive an award under this section, an insured must prevail in the litigation. *Manduca Datsun, Inc. v. Universal Underwriters Ins. Co.*, 106 Idaho 163, 676 P.2d 1274 (Ct. App. 1984).

Where insured prevailed on one issue and also successfully met challenges on other issues, it was entitled to a reasonable attorney fee on appeal. *Manduca Datsun, Inc. v. Universal Underwriters Ins. Co.*, 106 Idaho 163, 676 P.2d 1274 (Ct. App. 1984).

Where two insureds did not prevail on appeal in a dispute regarding coverage under a title insurance policy, they were not entitled to recover attorney fees. *Point of Rocks Ranch, LLC v. Sun Valley Title Ins. Co.*, 143 Idaho 411, 146 P.3d 677 (2006).

The loss caused by the collapse of the insureds’ outdoor above-ground swimming pool was not covered by the policy, as the pool was not a “household appliance.” The insurer was not obligated to pay the insureds any amount under the homeowners’ insurance policy, and the insureds’ request for attorney fees on appeal was denied. *Armstrong v. Farmers Ins. Co. of Idaho*, 147 Idaho 67, 205 P.3d 1203 (2009).

Where appellant insured’s suit for breach of an insurance contract and declaratory relief was dismissed, the insured was not the prevailing party and was not entitled to recover attorney fees under subsection (1) of this

section or subsection (3) of § 12-120. *Villa Highlands, LLC v. Western Cmty. Ins. Co.*, 148 Idaho 598, 226 P.3d 540 (2010).

Because an insurer had not paid any money to the insureds before suit was filed, nor had it tendered payment and paid the sum into court, the insureds were the prevailing parties under this section. *Idaho R. Civ. P. 54(d)(1)(B)* did not apply to determining the prevailing party because its requirement to compare the relief sought with the result obtained would be inconsistent with this section. *Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland)*, 153 Idaho 94, 279 P.3d 80 (2012).

Proof of Loss.

An insurer waived the requirement that proof of loss be furnished by denying liability as insurance carrier of the holder of a workmen's [now worker's] compensation policy. *Martin v. Argonaut Ins. Co.*, 91 Idaho 885, 434 P.2d 103 (1967).

"Proof of loss" requirements under this section cannot be any greater than the requirements for establishing a prima facie case of death under § 15-1-107. *Thomas v. John Hancock Mut. Life Ins. Co.*, 113 Idaho 98, 741 P.2d 734 (Ct. App. 1987).

The information furnished in the "Statement of Disappearance" deemed sufficient at trial to establish a prima facie case for declaring the beneficiary's husband dead was sufficient to constitute proof of loss under this section. *Thomas v. John Hancock Mut. Life Ins. Co.*, 113 Idaho 98, 741 P.2d 734 (Ct. App. 1987).

Where insured did not have to submit a proof of loss because insurance company never required him to do so, the settlement brochure qualified as such under this section. *Brinkman v. Aid Ins. Co.*, 115 Idaho 346, 766 P.2d 1227 (1988), overruled on other grounds, *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006).

Insurance policies cannot require more proof than is necessary for a prima facie case therefore, the insured, when required to do so under his policy, should provide the information reasonably available to him regarding his injury and the circumstances of the accident and the amount of information provided should be proportional to the amount reasonably available to the insured and if the information provided is insufficient to

give the insurer an opportunity to investigate and determine its liability, the insurer may deny coverage. *Brinkman v. Aid Ins. Co.*, 115 Idaho 346, 766 P.2d 1227 (1988), overruled on other grounds, *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006).

A submitted proof of loss is sufficient when the insured provides the insurer with enough information to allow the insurer a reasonable opportunity to investigate and determine its liability and mentions a specific sum so that a tender can be made, or provides the basis for calculating the amount of the claimed loss. *Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland)*, 153 Idaho 94, 279 P.3d 80 (2012).

There is no requirement that a proof of loss include a theory of coverage. *Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland)*, 153 Idaho 94, 279 P.3d 80 (2012).

Punitive Damages.

In the case of an insurance company which initially refuses to pay a valid claim when liability under the policy is later established, the plaintiff may be entitled to an award of attorney fees, but to be entitled to an award of punitive damages the plaintiff must show in addition, that the company's refusal promptly to pay the claim was an extreme deviation from reasonable standards of conduct, performed with an understanding of its consequences. *Linscott v. Rainer Nat'l Life Ins. Co.*, 100 Idaho 854, 606 P.2d 958 (1980).

Purpose.

The purpose of this section is to guarantee that the insured who are forced to litigate performance of the insurance contract receive the full amount due undiminished by the costs of litigation. *Berglund v. Potlatch Corp.*, 129 Idaho 752, 932 P.2d 875 (1996).

The purpose of the statute is to provide an incentive for insurers to settle just claims in order to reduce the amount of litigation and the high costs associated with litigation and to prevent the sum that is due the insured under the policy from being diminished by expenditures for services of an attorney. *Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland)*, 153 Idaho 94, 279 P.3d 80 (2012).

Refusal of Insurer to Defend Insured.

Attorney fees were properly awarded in an action on a products liability policy where the insurer refused to defend the insured in an action by a customer claiming damages for failure of seeds purchased in Idaho, delivered in Arizona, and planted in Mexico and based such refusal on a clause in the policy limiting the policy to occurrences arising during the policy period within the United States, its territories or possessions, or Canada. *Shields v. Hiram C. Gardner, Inc.*, 92 Idaho 423, 444 P.2d 38 (1968).

Refusal to Pay.

Although the medical malpractice insurer breached its duty to defend its insured doctor, where the doctor's tortious sexual acts were not such acts as would be covered within the meaning of the policy's definition of "professional services," there could be no "amount justly due" under that medical malpractice insurance policy and the insurer was not liable for attorney fees for not paying off under the policy. *Hirst v. St. Paul Fire & Marine Ins. Co.*, 106 Idaho 792, 683 P.2d 440 (Ct. App. 1984).

Summary Judgment Inapplicable.

An assertion that a party is entitled to attorney's fees under this section is not a claim for relief to which a summary judgment motion would be applicable. Attorney's fees are simply costs awarded incident to prevailing on a cause of action. *Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland)*, 153 Idaho 94, 279 P.3d 80 (2012).

Surety.

By its plain meaning, subsection (3) was intended to hasten the resolution of consumers' claims and afford sureties a degree of discretion in settling undisputed claims. *Hestead v. CNA Supply*, 152 Idaho 575, 272 P.3d 547 (2012).

Time Limitation.

Because the thirty-day limit in subsection (1) is for the insured's benefit, the insured can agree to extend the time when the 30-day period begins to run or when it is deemed to expire. *Holland v. Metro. Prop. & Cas. Ins. Co. (In re Estate of Holland)*, 153 Idaho 94, 279 P.3d 80 (2012).

Voluntary Payment.

Any right an insurer has to contest the amount “justly due” is waived upon its voluntary payment of a greater amount. *Jones v. State Farm Mut. Auto Ins. (In re Jones)*, 2009 Bankr. LEXIS 5520 (D. Idaho June 22, 2009).

Waiver of Proof of Loss Requirement.

Where the insurance company rejected the tender of defense made to it by an additional insured under the policy, it in effect denied any liability as the insurance carrier and thereby waived any requirement that proof of loss be furnished as a prerequisite to recovery of attorney fees. *Bonner County v. Panhandle Rodeo Ass’n*, 101 Idaho 772, 620 P.2d 1102 (1980).

Cited *Sunset Life Ins. Co. of Am. v. Crosby*, 85 Idaho 407, 380 P.2d 9 (1963); *Heath v. Utah Home Fire Ins. Co.*, 89 Idaho 490, 406 P.2d 341 (1965); *Lewis v. Continental Life and Acc. Co.*, 93 Idaho 348, 461 P.2d 243 (1969); *Benner v. Farm Bureau Ins. Co. of Idaho, Inc.*, 96 Idaho 311, 528 P.2d 193 (1974); *Wardle v. International Health & Life Ins. Co.*, 97 Idaho 668, 551 P.2d 623 (1976); *Foremost Ins. Co. v. Putzier*, 102 Idaho 138, 627 P.2d 317 (1981); *Linn v. North Idaho Dist. Medical Serv. Bureau, Inc.*, 102 Idaho 679, 638 P.2d 876 (1981); *Idaho Power Co. v. Idaho Pub. Utils. Comm’n*, 102 Idaho 744, 639 P.2d 442 (1981); *Goodwin v. Nationwide Ins. Co.*, 104 Idaho 74, 656 P.2d 135 (Ct. App. 1982); *DeWils Interiors, Inc. v. Dines*, 106 Idaho 288, 678 P.2d 80 (Ct. App. 1984); *Ferrel v. Allstate Ins. Co.*, 106 Idaho 696, 682 P.2d 649 (Ct. App. 1984); *Sunshine Mining Co. v. Allendale Mut. Ins. Co.*, 107 Idaho 25, 684 P.2d 1002 (1984); *Luzar v. Western Sur. Co.*, 107 Idaho 693, 692 P.2d 337 (1984); *Dullenty v. Rocky Mt. Fire & Cas. Co.*, 107 Idaho 777, 692 P.2d 1209 (Ct. App. 1984); *Sullivan v. Allstate Ins. Co.*, 111 Idaho 304, 723 P.2d 848 (1986); *Sivak v. State*, 112 Idaho 127, 730 P.2d 1047 (Ct. App. 1986); *Idaho v. Bunker Hill Co.*, 662 F. Supp. 725 (D. Idaho 1987); *Greene v. Truck Ins. Exch.*, 114 Idaho 63, 753 P.2d 274 (Ct. App. 1988); *Mutual of Enumclaw v. Harvey*, 115 Idaho 1009, 772 P.2d 216 (1989); *Holscher v. James*, 124 Idaho 443, 860 P.2d 646 (1993); *Seubert Excavators, Inc. v. Eucon Corp.*, 125 Idaho 744, 874 P.2d 555 (Ct. App. 1993), rev’d on other grounds, 125 Idaho 409, 871 P.2d 826 (1994); *State v. Gardiner*, 127 Idaho 156, 898 P.2d 615 (Ct. App. 1995); *Mutual of Enumclaw Ins. Co. v. Roberts*, 128 Idaho 232, 912 P.2d 119 (1996); *State Farm Mut. Auto. Ins. Co. v. Robinson*, 129 Idaho 447, 926 P.2d 631 (1996); *Boel v. Stewart Title Guar. Co.*, 137 Idaho 9, 43 P.3d 768 (2002); *Howard v. Or. Mut. Ins. Co.*, 137 Idaho 214, 46 P.3d 510

(2002); *Hoyle v. Utica Mut. Ins. Co.*, 137 Idaho 367, 48 P.3d 1256 (2002); *Graham v. State Farm Mut. Auto. Ins. Co.*, 138 Idaho 611, 67 P.3d 90 (2003); *Greenough v. Farm Bureau Mut. Ins. Co.*, 142 Idaho 589, 130 P.3d 1127 (2006); *Arreguin v. Farmers Ins. Co.*, 145 Idaho 459, 180 P.3d 498 (2008); *Cherry v. Coregis Ins. Co.*, 146 Idaho 882, 204 P.3d 522 (2009); *Hill v. Am. Family Mut. Ins. Co.*, 150 Idaho 619, 249 P.3d 812 (2011); *Farm Bureau Mut. Ins. Co. v. Eisenman*, 153 Idaho 549, 286 P.3d 185 (2012); *Lakeland True Value Hardware, LLC v. Hartford Fire Ins. Co.*, 153 Idaho 716, 291 P.3d 399 (2012); *Emplrs Mut. Cas. Co. v. Donnelly*, 154 Idaho 499, 300 P.3d 31 (2013); *Jackson Hop, LLC v. Farm Bureau Mut. Ins. Co.*, 158 Idaho 894, 354 P.3d 456 (2015); *Scout, LLC v. Truck Ins. Exch.*, 164 Idaho 593, 434 P.3d 197 (2019).

Decisions Under Prior Law

Attorney fees.

Impairment of obligation.

Attorney Fees.

Provision of former law allowing attorney fees in suit on bond applied to bond under Miller Act (40 U.S.C.S. § 270a et seq.) though bond was executed prior to enactment of provision. *United States ex rel. Midwest Steel & Iron Works Co. v. Henly*, 117 F. Supp. 928 (D. Idaho 1954).

Attorney fees could be collected on the basis of former § 41-1403 (now repealed) by virtue of a supplemental accidental benefit issued in 1953 though original contract of insurance was issued in 1941, since the supplemental contract based on an additional or independent consideration became a separate contract. *Gem State Mut. Life Ass'n v. Gray*, 77 Idaho 157, 290 P.2d 217 (1955).

Where attempted cancellation of fire insurance policy by agency was an attempt to perpetrate a fraud upon insured and insurer ratified acts of agency, insured who recovered face amount of policy was entitled to award of attorney's fee for prosecution of action in district court and to additional attorney's fee for defending the judgment upon appeal. *Lewis v. Snake River Mut. Fire Ins. Co.*, 82 Idaho 329, 353 P.2d 648 (1960).

The district court lacked authority under this section to award an attorney's fee to plaintiff for representation upon appeal of action for

recovery under two (2) insurance policies covering hospital and surgical expenses in the event of accident or sickness. *Molstead v. Reliance Nat. Life Ins. Co.*, 83 Idaho 458, 364 P.2d 883 (1961).

The district court lacked authority under this section to award the attorney's fee to respondent for representation upon an appeal. The authority to award an attorney's fee upon the appeal rests with the supreme court contingent upon determination that an amount is justly due under the insurance contract. Further, the jurisdiction of the supreme court must be invoked by suitable pleading. *Molstead v. Reliance Nat. Life Ins. Co.*, 83 Idaho 458, 364 P.2d 883 (1961).

The motion for allowance of attorney's fees in the supreme court on appeal of action under this section should be made before or at the time of filing brief and the opposing party should be afforded opportunity to contest the same before rendition of opinion on the merits. Permission in this case was granted to file motion for attorney's fees within 10 days, time for reply to be governed by Supreme Court Rule 13. *Molstead v. Reliance Nat. Life Ins. Co.*, 83 Idaho 458, 364 P.2d 883 (1961).

The trial court did not abuse its discretion in awarding \$3,000 as a reasonable attorney fee to respondents after having fixed respondents' insured loss at \$10,908 where parties had stipulated, should the court find for respondents and that they were entitled to attorney fees, that the court might fix a reasonable attorney fee without proof under former law which in part provided that upon failure to pay to the person entitled the amount justly due under an insurance policy, the surety should have in any action brought against the insurer for recovery under the policy paid such further amount as attorney fees in such action as decreed by the court. *Coburn v. Fireman's Fund Ins. Co.*, 86 Idaho 415, 387 P.2d 598 (1963).

Impairment of Obligation.

Former law providing for recovery of attorney fees by plaintiff in suit on a bond did not impair the obligation of contract but merely enlarged remedy as there was no liability for attorney fees if there was no liability under the bond. *United States ex rel. Midwest Steel & Iron Works Co. v. Henly*, 117 F. Supp. 928 (D. Idaho 1954).

Former law providing for allowance of attorney fees in actions upon insurance policies where insurance company failed to pay “amount justly due under such policy” impaired the obligation of contract insofar as act applied to policies issued prior to effective date of act. *Penrose v. Commercial Travelers Ins. Co.*, 75 Idaho 524, 275 P.2d 969 (1954).

RESEARCH REFERENCES

Idaho Law Review. — Attorney Fee Awards in Idaho: A Handbook, Comment. 52 Idaho L. Rev. 583 (2016).

§ 41-1840. Prepayment of claims. — (1) No payment or payments made by any person, or by his insurer by virtue of an insurance policy, on account of bodily injury or death or damage to or loss of property of another, shall constitute an admission of liability or waiver of defense as to such injury, death, loss or damage, or be admissible in evidence in any action brought against the insured person or his insurer for damages, indemnity or benefits arising out of such injury, death, loss or damage unless pleaded as a defense to the action.

(2) All such payments shall be credited upon any settlement with respect to the same damage, expense or loss made by, or judgment or award rendered therefor in such an action against, the payor or his insurer, and in favor of any person to whom or on whose account payment was made.

History.

I.C., § 41-1840, as added by 1969, ch. 214, § 49, p. 625.

CASE NOTES

Applicability.

Credit against verdict.

Prepayments.

— Admissible.

— Reimbursement requirement.

— Restriction.

Purpose.

Refusal to make advances.

Applicability.

This section applied to a situation in which both parties were insured by the same insurer and one of the parties claimed that her insurer was entitled to a credit; the matter was treated as if both parties were insured by separate entities, but the district court erred in the size of the award, as the amount

awarded exceeded the amount to be credited. *Schaffer v. Curtis-Perrin*, 141 Idaho 356, 109 P.3d 1098 (2005).

Credit Against Verdict.

Where plaintiff did not deny that defendant's insurer had made payments to plaintiff for property damage and medical bills, nor that those payments were for plaintiff's benefit, it was error to deny the defendant credit, for payments so made, against the jury verdict. *Potter v. Mulberry*, 100 Idaho 429, 599 P.2d 1000 (1979).

Prepayments.

— Admissible.

Because the damages in a case between a personal representative and a nursing home did not arise from a tort, but instead were contractual and not on account of bodily injury, death, or damage to property, the evidence of the nursing home insurer's payments was admissible for the purpose of showing the existence of a settlement agreement between the insurer and the personal representative and was not barred by subsection (1) of this section; the trial court erred in granting the nursing home summary judgment under *Idaho R. Civ. P. 56(c)* because issues of fact existed regarding whether the insurer and personal representative reached a common understanding that the personal representative agreed not to sue if the insurer agreed to pay the decedent's excess expenses caused by the nursing home's alleged negligence and whether there was consideration. *McColm-Traska v. Valley View, Inc.*, 138 Idaho 497, 65 P.3d 519 (2003).

— Reimbursement Requirement.

If a defendant pays a plaintiff amounts the plaintiff has incurred as a result of the defendant's tortious action, and the plaintiff does not then seek to recover for those amounts at trial, the defendant is simply not entitled to credit; in other words, there can be no "requirement" for reimbursement where there is no recovery sought for the same expenses that were previously paid. *Beale v. Speck*, 127 Idaho 521, 903 P.2d 110 (Ct. App. 1995).

— Restriction.

This section restricts the credit allowed for advance payments to those amounts actually sought and received by the plaintiffs at trial, and, in accord with the statutory language, the amounts credited must be for the same damages as those recovered by the plaintiff at trial. *Beale v. Speck*, 127 Idaho 521, 903 P.2d 110 (Ct. App. 1995).

Purpose.

Although the language of this statute refers at times to “any person” and at times to “the insured,” the purpose of the provision is to encourage any defendant, insured or otherwise, to assist an injured adversary in alleviating any losses suffered without the fear of providing an admission which could result in the imposition of liability. *Tommerup v. Albertson’s, Inc.*, 101 Idaho 1, 607 P.2d 1055 (1980).

The purpose of this statute is to encourage tort-feasors and their insurers to alleviate financial hardship inflicted on accident victims without fear of having the evidence of prepayments being introduced at trial. *Turner v. Willis*, 116 Idaho 682, 778 P.2d 804 (1989).

One of the purposes of the provision allowing credit for prepaid amounts is to prevent double recovery by the plaintiff who receives payments from the defendant or its insurer and then recovers those same amounts as part of his or her judgment; there will be no double recovery, however, if the damages awarded by the jury do not include amounts for losses or injuries which the defendant prepaid the plaintiff. *Beale v. Speck*, 127 Idaho 521, 903 P.2d 110 (Ct. App. 1995).

Refusal to Make Advances.

The district court did not err in giving due consideration to defendants’ refusal to make any advances on plaintiff’s sum-certain medical bills in awarding attorney fees to a prevailing personal injury plaintiff, especially given defendants’ belated admission of liability. *Turner v. Willis*, 116 Idaho 682, 778 P.2d 804 (1989).

Cited *Carlson v. Stanger*, 146 Idaho 642, 200 P.3d 1191 (Ct. App. 2008).

RESEARCH REFERENCES

ALR. — Application and construction of state offer of judgment rule — Determining whether offeror is entitled to award. [2 A.L.R.6th 279](#).

§ 41-1841. Block cancellations and block nonrenewals — Notice to director required. — (1) Any insurer intending to implement block cancellations or block nonrenewals of insurance policies shall provide the director written notice of such intentions no later than one hundred twenty (120) days prior to such intended action. Such notice shall fully set forth reasons for such action and shall include additional information that the director may deem appropriate. Failure by any insurer to comply with the requirements of this section shall constitute a violation of the provisions of this section and shall render any policy cancellations or nonrenewals by the insurer null and void and without effect. The failure of any insurer to comply with the requirements of this section shall not affect the contract rights of insureds.

(2) At the end of sixty (60) days the intended insurer action shall be deemed approved unless prior thereto it has been affirmatively approved by order of the director.

(3) Block cancellations or block nonrenewals for the provisions of this section and the enforcement of this code, shall be defined to include any of the following: cancellation or nonrenewal of any class, line, type or subject of insurance, or the withdrawal from the business of insurance in Idaho.

(4) The requirements of this section are not a waiver or limitation of the provisions of this code, or other laws of this state, but are additional requirements.

(5) The director may issue reasonable regulations to establish requirements for reporting required herein.

History.

I.C., § 41-1841, as added by 1986, ch. 310, § 1, p. 761.

§ 41-1842. Commercial insurance — Cancellation — Nonrenewal. —

(1) Applicability. The provisions of this section apply only to:

- (a) Commercial property insurance policies;
- (b) Commercial liability insurance policies other than aviation and employer's liability insurance policies;
- (c) Commercial multiperil insurance policies.

The provisions of this section do not apply to: block cancellations or block nonrenewals as provided in [section 41-1841, Idaho Code](#), reinsurance, excess and surplus lines insurance, residual market risks, worker's compensation insurance, multistate location risks, policies subject to retrospective rating plans, excess or umbrella policies and such other policies that are exempted by the director of the department of insurance.

(2) Definitions. For the purposes of this section:

- (a) "Cancellation" means termination of a policy at a date other than its expiration date.
- (b) "Expiration date" means the date upon which coverage under a policy ends. It also means, for a policy written for a term longer than one (1) year or with no fixed expiration date, each annual anniversary date of such policy.
- (c) "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premiums on a policy of insurance subject to this section, whether such payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit.
- (d) "Nonrenewal" or "not to renew" means termination of a policy at its expiration date.
- (e) "Renewal" or "to renew" means the issuance, or the offer so to issue, by an insurer of a policy succeeding a policy previously issued and delivered by the same insurer or an insurer within the same group of

insurers, or the issuance of a certificate or notice extending the term of an existing policy for a specified period beyond its expiration date.

(3) Notice of cancellation.

(a) Permissible cancellations. If coverage under a policy has not been in effect for sixty (60) days and the policy is not a renewal, cancellation of such policy shall be effected by mailing or delivering a written notice to the first-named insured at the last known mailing address shown on the policy at least thirty (30) days before the effective date of the cancellation, provided however, if such cancellation is for the reason stated in subsection (3)(a)(i) of this section, the time such cancellation may be effective following notice shall be as provided in subsection (3)(b)(i) of this section. A cancellation requested by the insured shall be effective on the later of the date requested by the insured or the date it is received by the insurer. After coverage has been in effect for more than sixty (60) days or after the effective date of a renewal policy, whichever is earlier, no insurer shall cancel a policy unless the cancellation is based on at least one (1) of the following reasons:

(i) Nonpayment of premium.

(ii) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

(iii) Activities or omissions on the part of the named insured which increase any hazard insured against, including a failure to comply with loss control recommendations.

(iv) Change in the risk which materially increases the risk of loss after insurance coverage has been issued or renewed including, but not limited to, an increase in exposure to regulation, legislation or court decision.

(v) Loss or decrease of the insurer's reinsurance covering all or part of the risk or exposure by the policy.

(vi) Determination by the director that the continuation of the policy would jeopardize an insurer's solvency or would place the insurer in violation of the insurance laws of this state or any other state.

(vii) Violation or breach by the insured of any policy terms or conditions other than nonpayment of premium.

(b) Notification of cancellation.

(i) A notice of cancellation of insurance coverage by an insurer shall be in writing and shall be mailed or delivered to the first-named insured at the last known mailing address as shown on the policy. Notices of cancellation based on subsections (3)(a)(ii) through (a)(vii) of this section shall be mailed or delivered at least thirty (30) days prior to the effective date of the cancellation. Notices of cancellation for the reason stated in subsection (3)(a)(i) of this section without regard to when such cancellation shall be effected shall be mailed or delivered at least ten (10) days prior to the effective date of cancellation. If delivered via United States mail, the ten (10) day notification period shall begin to run five (5) days following the date of postmark. The notice shall state the effective date of the cancellation.

(ii) The insurer shall provide the first-named insured with a written statement setting forth the reason(s) for the cancellation if: (1) the insured requests such a statement in writing; and (2) the named insured agrees in writing to hold the insurer harmless from liability for any communication giving notice of or specifying the reasons for a cancellation or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for a cancellation under this section.

(4) Notice of nonrenewal.

(a) An insurer may decline to renew a policy if the insurer delivers or mails to the first-named insured, at the last known mailing address, written notice that the insurer will not renew the policy. Such notice shall be mailed or delivered at least forty-five (45) days before the expiration date. If the notice is mailed less than forty-five (45) days before expiration, coverage shall remain in effect until forty-five (45) days after notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this section, the transfer of a policyholder between companies within the same insurance group is not a nonrenewal or a refusal to renew. In addition, changes in

deductibles, changes in premium, and changes in the amount of insurance or reductions in policy limits or coverage shall not be deemed to be nonrenewals or refusals to renew. Notice of nonrenewal is not required if:

- (i) The insurer or a company within the same insurance group has offered to issue a renewal policy; or
 - (ii) Where the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.
- (b) If an insurer provides the notice described in subsection (4) of this section and thereafter the insurer extends the policy for ninety (90) days or less, an additional notice of nonrenewal is not required with respect to the extension.

(5) Notice of premium or coverage changes. An insurer shall mail or deliver to the named insured, at the last known mailing address, written notice of a total premium increase greater than ten percent (10%) which is the result of a comparable increase in premium rates, changes in deductibles, reductions in limits, or reductions in coverages at least thirty (30) days prior to the expiration date of the policy. If the insurer fails to provide such thirty (30) day notice, the coverage provided to the named insured shall remain in effect until thirty (30) days after such notice is given or until the effective date of replacement coverage obtained by the named insured, whichever first occurs. For the purposes of this section, notice is considered given thirty (30) days following date of mailing or delivery of the notice to the named insured. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective on and after the first day of the renewal term.

(6) Proof of notice. Proof of mailing of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the named insured at the last known mailing address showing on the policy, shall be sufficient proof of notice.

(7) Application, effective date and termination. The provisions of this section shall apply only to policies with coverage effective dates after the effective date of this section.

(8) Rules. The director may promulgate rules to implement the provisions of this section. Every rule promulgated within the authority conferred by this act shall be of temporary effect and shall become permanent only by enactment by statute at the regular session of the legislature first following adoption of the rule. Rules not approved in the above manner shall be rejected, null, void and of no force and effect on July 1, following submission of the rules to the legislature.

History.

I.C., § 41-1842, as added by 1990, ch. 240, § 2, p. 682; am. 1993, ch. 231, § 1, p. 803; am. 2006, ch. 359, § 2, p. 1092.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 359, in subsection (3)(b)(i), added the fourth sentence.

Compiler's Notes.

The phrase “the effective date of this section” in subsection (7) refers to the effective date of S.L. 1990, chapter 240, § 2, which was effective July 1, 1990.

The term “this act” in the second sentence in subsection (8) refers to S.L. 1990, Chapter 240, which is currently codified as §§ 41-1815, 41-1842, and 41-2401.

Effective Dates.

Section 2 of S.L. 1993, ch. 231 provided that the act shall be in full force and effect on October 1, 1993.

§ 41-1843. Insurance rates and credit rating. — (1) No insurer regulated pursuant to this title shall charge a higher premium than would otherwise be charged, or cancel, nonrenew or decline to issue a property or casualty policy or coverage based primarily upon an individual's credit rating or credit history.

(2) As used in this section, “based primarily” means that the weight given by the insurer to an individual's credit rating or credit history exceeds the weight given by the insurer to all other criteria considered in making the decision to charge a higher premium or to cancel, nonrenew or decline to issue an insurance policy.

(3) This section shall apply only to property or casualty insurance, as defined in chapter 5, title 41, Idaho Code, to be used primarily for personal, family or household purposes.

History.

I.C., § 41-1843, as added by 2002, ch. 264, § 1, p. 786.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2002, ch. 264 provided that the act should take effect on and after January 1, 2003.

§ 41-1844. Prescription drug benefit restrictions prohibited. — (1) A group policy or contract providing for third-party payment or prepayment for prescription drugs may designate an affiliated mail order pharmacy or other specific pharmacy but it shall not require a person covered under the policy or contract to obtain prescription drugs from the mail order pharmacy or any specifically designated pharmacy, nor shall it set forth provisions for the payment of additional fees or deductibles by the covered person as a condition of obtaining benefits for prescription drugs if a registered pharmacy selected by the covered person agrees to provide pharmaceutical services under the same terms and conditions as those provided by said mail order pharmacy or specifically designated pharmacy.

(2) Group policy or contracts providing for third-party payment or for prescription drugs delivered, issued for delivery, continued, or renewed in this state on or after July 1, 1991, are subject to the provisions of this section.

History.

I.C., § 41-1844, as added by 1991, ch. 123, § 1, p. 268.

§ 41-1845. Recreational-related activities. — (1) No company providing health insurance benefits may:

(a) Deny health care coverage to any individual based solely on that individual's casual or nonprofessional participation in the following activities: motorcycling, snowmobiling, off-highway vehicle riding, skiing, snowboarding, horseback riding or similar activities; or

(b) Exclude medical benefits under health care coverage to any covered individual based solely on that individual's casual or nonprofessional participation in the following activities: motorcycling, snowmobiling, off-highway vehicle riding, skiing, snowboarding, horseback riding or similar activities.

(2) Nothing in this section shall preclude, alter or otherwise affect the subrogation rights of companies providing health insurance benefits.

History.

I.C., § 41-1845, as added by 2003, ch. 303, § 1, p. 833.

§ 41-1846. Health care policies — Applicability — Requirement. —

(1) An insurer offering a health care policy that does not meet the definition of a managed care plan as provided in [section 41-3903\(15\), Idaho Code](#):

(a) Must have the intent to render and the capability for rendering or providing coverage for good quality health care services, which will be and are readily available and accessible to its insureds both within and outside the state of Idaho, and such services must be reasonably responsive to the needs of insureds;

(b) When “emergency services” are provided, they shall be provided as set forth in [section 41-3903\(7\), Idaho Code](#), and shall not require prior authorization;

(c) Shall include on its website and/or send annually to its policyholders:

(i) A statement as to whether the plan includes a limited formulary of medications and a statement that the formulary will be made available to any member on request;

(ii) Notification of any change in benefits; and

(iii) A description of all prior authorization review procedures for health care services;

(d) Shall adopt procedures for a timely review by a licensed physician, peer provider or peer review panel when a claim has been denied as not medically necessary or as experimental. The procedure shall provide for a written statement of the reasons the service was denied and transmittal of that information to the appropriate provider for inclusion in the insured’s permanent medical record;

(e) When prior approval for a covered service is required of and obtained by or on behalf of an insured, the approval for the specific procedure shall be final and may not be rescinded after the covered service has been provided except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits or if the insured for whom the prior approval was granted is not enrolled at the time the covered service was provided; and

(f) Shall not offer a provider any incentive that includes a specific payment made, in any type or form, to the provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered by the health care policy.

(2) No health care provider shall require an insured to make additional payments for covered services under a policy subject to subsection (1) of this section, other than specified deductibles, copayments or coinsurance once a provider has agreed in writing to accept the insurer's reimbursement rate to provide a covered service.

History.

I.C., § 41-1846, as added by 2004, ch. 283, § 1, p. 798.

STATUTORY NOTES

Effective Dates.

Section 3 of S.L. 2004, ch. 283 provided: "This act shall be in full force and effect on and after July 1, 2004, and shall apply to health care policies renewing or written after July 1, 2004."

§ 41-1847. Assignment of health insurance contracts. — (1) No insurer, as defined in [section 41-5601, Idaho Code](#), shall assign the benefits of any contract with a practitioner or facility, as defined in [section 41-5601, Idaho Code](#), that contains an agreement by the practitioner or facility to provide services to a patient covered by the insurer at a fee which is discounted from that practitioner's or facility's usual and customary fee, unless the contract between the insurer and the practitioner or facility, in conspicuous and plain language, specifically permits the contract to be assigned.

(2) An insurer shall send prompt written or electronic notice to the practitioner or facility, in conformance with the notice provisions of the contract between the insurer and the practitioner or facility, of each assignment it makes that is permitted by subsection (1) of this section. The notice shall identify the name and principal business address of each assignee.

(3) An assignment in violation of this section shall be void. The director shall enforce the provisions of this section and shall review and, if appropriate, investigate complaints received by the department related to noncompliance with the provisions of this section. If the director determines an insurer has violated the provisions of this section, the director may impose an administrative fine not to exceed five thousand dollars (\$5,000) based upon an enforcement action. The director shall not suspend or revoke an insurer's certificate of authority for violation of this section. This section shall not create a private cause of action by or on behalf of a beneficiary or practitioner or facility against an insurer.

History.

[I.C., § 41-1847](#), as added by 2008, ch. 139, § 1, p. 400.

§ 41-1848. Legislative findings and purpose — Coverage for abortions in state exchange prohibited. — (1) The legislature finds that:

(a) Pursuant to section 1303 of the patient protection and affordable care act, **P.L. 111-148**, states are explicitly permitted to pass laws prohibiting qualified health plans offered through an exchange in their state from offering abortion coverage;

(b) It is the longstanding policy of this state to prefer live childbirth over abortion and to prohibit the use of taxpayer moneys to fund abortions unless the mother's life is at risk or the pregnancy is a result of rape or incest;

(c) Idaho law prohibits certain insurance plans, policies and contracts issued in this state from offering coverage for elective abortions; and

(d) It is the purpose of this section to affirmatively prohibit qualified health plans that cover abortions from participating in exchanges within this state.

(2) Notwithstanding any other provision of law, no abortion coverage may be provided by a qualified health plan offered through an exchange created pursuant to the patient protection and affordable care act, **P.L. 111-148**, within the state of Idaho.

(3) The provisions of subsection (2) of this section shall not apply to an abortion performed if it is the recommendation of one (1) consulting physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape, as defined in **section 18-6101, Idaho Code**, or incest as determined by the courts.

History.

I.C., § 41-1848, as added by 2011, ch. 152, § 1, p. 436.

STATUTORY NOTES

Federal References.

P.L. 111-148, the patient protection and affordable care act, referred to in this section, is generally codified in title 42 of the United States Code. Section 1303 of the act, referred to in paragraph (1)(a), is codified as 42 USCS § 18023.

§ 41-1849. Contracts with providers of dental services. — (1) No person contracting with dentists to provide coverage or reimbursement for dental services may require, as an element of any dental care provider participation contract, that the provider agree to adopt fees set by the person for dental care services that are not covered services under the contract. “Covered services” as used in this section means dental care services and procedures under the applicable dental plan, dental plan contract, or plan benefits for which payment is available to the covered person or dentist under the covered person’s plan or contract or for which payment to the covered person or to the dentist would be available but for the application of contractual limitations on reimbursement, such as deductibles, copayments, coinsurance, and waiting periods. All services or procedures are no longer covered services, and the plan can no longer impose, contractually or otherwise, a fee schedule or other limitation when the following criteria have been met:

- (a) When the third-party payer is no longer liable for paying for an individual service or a procedure, in part or in whole, due to calendar-year limitations or benefit-year limitations; and
- (b) A patient has received dental services and procedures that equal an additional one hundred percent (100%) of the amount of the patient’s capped annual maximum benefit for the calendar year or benefit year.

Once a patient’s capped annual maximum benefit amount for a calendar year or benefit year has been exceeded by one hundred percent (100%), a dentist may choose to provide dental services or procedures according to a plan’s fee schedule or to provide dental services or procedures at a fee agreed upon with the patient. The dentist must confer with and provide notice to the patient regarding the patient’s change in fee status, and any agreed-upon fee shall not exceed the lowest fee available to the dentist’s uninsured patients.

(2) This section shall apply to any contract with providers for dental services that is issued after December 31, 2019. Contracts that are in existence on December 31, 2019, shall be brought into compliance on the

next anniversary date, the renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest.

History.

I.C., § 41-1849, as added by 2010, ch. 126, § 1, p. 272; am. 2019, ch. 153, § 1, p. 505.

STATUTORY NOTES

Amendments.

The 2019 amendment, by ch. 153, rewrote the section to the extent that a detailed comparison is impracticable.

§ 41-1850. Certificates of insurance. — (1) For purposes of this section, the following terms have the following meanings:

(a) “Certificate” or “certificate of insurance” means any document or instrument, no matter how titled or described, that is prepared or issued as evidence of property or casualty insurance coverage. “Certificate” or “certificate of insurance” shall not include a policy of insurance, insurance binder, policy endorsement or automobile insurance identification card.

(b) “Certificate holder” means any person, other than a policyholder, that requests, obtains or possesses a certificate of insurance.

(c) “Insurance producer” has the same meaning as provided for in chapter 10, title 41, Idaho Code.

(d) “Insurer” has the same definition as provided for in [section 41-103, Idaho Code](#).

(e) “Person” means any individual, partnership, corporation, association or other legal entity, including any government or governmental subdivision or agency.

(f) “Policyholder” means a person that has contracted with a property or casualty insurer for insurance coverage.

(g) “Group master policy” means an insurance policy that provides coverage to eligible persons on a group basis through a group insurance program.

(2) No person, wherever located, may prepare, issue or knowingly request the issuance of a certificate of insurance unless the form has been filed with the director by or on behalf of an insurer. No person, wherever located, may alter or modify a certificate of insurance form unless the alteration or modification has been filed with the director.

(3) The director shall disapprove the use of any form filed under this section, or withdraw approval of a form, if the form:

(a) Is unfair, misleading or deceptive, or violates public policy;

(b) Fails to comply with the requirements of this section; or

(c) Violates any provision of title 41, Idaho Code, including any rule promulgated by the director.

(4) Each certificate of insurance must contain the following or similar statement: “This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not alter, amend or extend the coverage, terms, exclusions and conditions afforded by the policies referenced herein.”

(5) The current edition of standard certificate of insurance forms promulgated and filed with the director by the association for cooperative operations research and development (ACORD) or the insurance services office (ISO) are not required to be refiled by individual insurers.

(6) No person, wherever located, shall demand or request the issuance of a certificate of insurance or other document, record or correspondence that the person knows contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(7) No person, wherever located, may knowingly prepare or issue a certificate of insurance or other document, record or correspondence that contains any false or misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(8) The provisions of this section shall apply to all certificate holders, policyholders, insurers, insurance producers and certificate of insurance forms issued as evidence of property or casualty insurance coverages on property, operations or risks located in this state, regardless of where the certificate holder, policyholder, insurer or insurance producer is located.

(9) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively alter, amend or extend the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance provides.

(10) A certificate of insurance may not warrant that the policy of insurance referenced in the certificate comply with the insurance or indemnification requirements of a contract, and the inclusion of a contract number or description, or project number or description, within a certificate of insurance may not be interpreted as doing such. Notwithstanding any requirement, term or condition of any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance is subject to all the terms, exclusions and conditions of the policy itself.

(11) A person is entitled to receive notice of cancellation, nonrenewal or any material change or any similar notice concerning a policy of insurance only if the person has such notice rights under the terms of the policy or any endorsement to the policy. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.

(12) Any certificate of insurance or any other document, record or correspondence prepared, issued or requested in violation of this section shall be null and void and of no force and effect.

(13) Any person that violates this section shall be subject to an administrative penalty imposed by the director in an amount as provided for in [section 41-117, Idaho Code](#), per violation.

(14) The director shall have the power to examine and investigate the activities of any person that the director believes has been or is engaged in an act or practice prohibited by this section. The director shall have the power to enforce the provisions of this section and impose any authorized penalty or remedy against any person that violates this section.

(15) The director may, in accordance with [section 41-211, Idaho Code](#), adopt reasonable rules as are necessary or proper to carry out the provisions of this section.

(16) This section shall not apply to any certificate of insurance prepared and/or issued by an insurer pursuant to any federal law, rule or regulation, or any other law, rule or regulation of this state, in which the specific content and form of said certificate is enumerated therein, or a certificate

issued to a person or entity that has purchased coverage under a group master policy.

History.

I.C., § 41-1850, as added by 2012, ch. 314, § 1, p. 863; am. 2018, ch. 214, § 1, p. 483.

STATUTORY NOTES

Amendments.

The 2018 amendment, by ch. 214, rewrote the first sentence in subsection (10), which formerly read: “No certificate of insurance shall contain references to contracts other than the underlying contracts of insurance, including construction or service contracts.”

Compiler’s Notes.

For more information on the association for cooperative operations research and development (ACORD), referred to in subsection (5), see <https://www.acord.org/>.

The insurance services office, inc., referred to in subsection (5), became a wholly owned subsidiary of Verisk Analytics in October 2009. See <https://www.verisk.com/insurance/brands/iso/>.

Section 3 of S.L. 2012, ch. 314 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1851. Electronic notices and documents. — (1) In this section, the following words shall have the following meanings:

(a) “Delivered by electronic means” includes:

(i) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(ii) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet or any other electronic device, together with separate notice to a party directed to the electronic mail address at which the party has consented to receive notice of the posting;

(iii) Delivery or posting directly to a mobile device or other electronic device accessible by a party that has consented to conduct insurance transactions electronically.

(b) “Party” means any recipient of any notice or document required as part of an insurance transaction including, but not limited to, an applicant, an insured, a policyholder or an annuity contract holder.

(2) Pursuant to subsection (4) of this section, any notice to a party or any other document required under applicable law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored and presented by electronic means so long as it meets the requirements of the uniform electronic transactions act, chapter 50, title 28, Idaho Code.

(3) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under applicable law, including: delivery by first class mail; first class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.

(4) A notice or document may be delivered by electronic means by an insurer to a party under this section if the party has affirmatively consented to that method of delivery and has not withdrawn the consent.

(5) This section does not affect requirements related to content or timing of any notice or document required under applicable law.

(6) If a provision of this title or applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt. In the absence of verification or acknowledgment of receipt, the insurer shall mail a paper copy of the notice or document within three (3) days via United States mail.

(7) The legal effectiveness, validity or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party.

(8)(a) A withdrawal of consent by a party does not affect the legal effectiveness, validity or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(b) A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(9) The provisions of this section do not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this act to a party who, before that date, has consented to receive notice or document in an electronic form otherwise allowed by law.

(10) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this act, and pursuant to the provisions of this section, an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or documents electronically the insurer shall notify the party of:

(a) The notices or documents that may be delivered by electronic means under this section that were not previously delivered electronically; and

(b) The party's right to withdraw consent to have notices or documents delivered by electronic means.

(11)(a) Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may

qualify as a notice or document delivered by electronic means for the purposes of this section.

(b) If a provision of this title or applicable law requires a signature or notice or document to be notarized, acknowledged, verified or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice or document.

(12) The provisions of this section may not be construed to modify, limit or supersede the provisions of the federal electronic signatures in global and national commerce act, [P.L. 106-229](#), as amended.

History.

[I.C., § 41-1851](#), as added by 2013, ch. 269, § 1, p. 697.

STATUTORY NOTES

Federal References.

The federal electronic signatures in global and national commerce act, [P.L. 106-229](#), referred to in subsection (12), is codified as [15 U.S.C.S. § 7001 et seq.](#)

Compiler's Notes.

The phrase “the effective date of this act” in subsections (9) and (10) refers to the effective date of S.L. 2013, Chapter 269, which was effective July 1, 2013.

§ 41-1852. Discrimination against living organ donors prohibited. —

(1) For purposes of this section, “policy” means a life insurance policy, disability insurance policy or long-term care insurance policy.

(2) Notwithstanding any provision of law to the contrary, it shall be unlawful to discriminate against a person in the offering, issuance, cancellation, price or conditions of a policy, or in the amount of coverage provided under a policy, based solely and without any additional actuarial risks on the status of such person as a living organ donor.

(3) The director of the department of insurance may take such actions authorized under this title that are necessary to enforce this section.

History.

I.C., § 41-1852, as added by 2018, ch. 167, § 1, p. 341.

Chapter 19

LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS

Sec.

41-1901. Scope of chapter.

41-1902. “Industrial life insurance” defined.

41-1903. Standard provisions required.

41-1904. Grace period.

41-1905. Incontestability.

41-1906. Entire contract.

41-1907. Misstatement of age.

41-1908. Dividends.

41-1909. Policy loan.

41-1910. Table of installments.

41-1911. Reinstatement.

41-1912. Payment of premiums.

41-1913. Payment of claims.

41-1914. Beneficiary — Industrial policies.

41-1915. Title.

41-1916. Excluded or restricted coverage.

41-1917. Standard provisions — Annuity and pure endowment contracts.

41-1918. Grace period — Annuities.

41-1919. Incontestability — Annuities.

41-1920. Entire contract — Annuities.

41-1921. Misstatement of age or sex — Annuities.

41-1922. Dividends — Annuities.

41-1923. Reinstatement — Annuities.

41-1924. Standard provisions — Reversionary annuities.

41-1925. Limitation of liability.

41-1926. Prohibited provisions — Industrial life insurance.

41-1927. Standard nonforfeiture law — Life insurance.

41-1927A. Standard nonforfeiture law for individual deferred annuities.

41-1928. Nonforfeiture benefits — Certain interim policies.

41-1929. Incontestability and limitation of liability after reinstatement.

41-1930. Policy settlements.

41-1931. Indebtedness deducted from proceeds.

41-1932. Participating and nonparticipating policies — Right to issue.

41-1933. Participating and nonparticipating policies — Accounting.

41-1934. Prohibited policy plans.

41-1935. Life insurance and annuities — Twenty day free examination.

41-1936. Separate accounts — Operation and management.

41-1937. Variable contracts — Statement of essential features.

41-1938. Variable contracts — Authority of insurer to issue.

41-1939. Variable contracts — Regulation thereof.

41-1940. Suitability of annuity sales to consumers.

41-1941. Annuity sales to consumers — Disclosures.

41-1942. Advertisement of interest-indexed annuities.

41-1943. Standards for policy provisions for annuities.

41-1944 — 41-1949. [Reserved.]

41-1950. Short title and scope.

41-1951. Definitions.

41-1952. License requirement.

- 41-1953. Filing of life settlement contracts and disclosure statements.
- 41-1954. Reporting requirements and privacy.
- 41-1955. Examination and records.
- 41-1956. Disclosure to owner upon application.
- 41-1957. Disclosure to owner by provider upon settlement contract.
- 41-1958. Disclosure to owner by broker upon settlement contract.
- 41-1959. Notice of change by provider.
- 41-1960. General rules.
- 41-1961. Permitted life settlements and supporting documentation.
- 41-1962. Prohibited practices and conflicts of interest.
- 41-1963. Advertising for life settlements.
- 41-1964. Penalty — Unfair trade practices.
- 41-1965. Authority to promulgate rules.

§ 41-1901. Scope of chapter. — This chapter applies only to contracts of life insurance and annuities, other than reinsurance, group life insurance and group annuities.

History.

1961, ch. 330, § 432, p. 645.

STATUTORY NOTES

Cross References.

Life insurance benefits exempt from execution, § 11-604.

Simultaneous death of insured and beneficiary of insurance policy, distribution of proceeds of policy, § 15-2-613.

Venue of actions against life insurance companies, § 5-404.

§ 41-1902. “Industrial life insurance” defined. — For the purposes of this code “industrial life insurance” is that form of life insurance written under policies of face amount of one thousand dollars (\$1,000) or less bearing the words “industrial policy” imprinted on the face thereof as part of the descriptive matter, and under which premiums are payable monthly or more often.

History.

1961, ch. 330, § 433, p. 645.

§ 41-1903. Standard provisions required. — (1) No policy of life insurance other than group, and pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in this state unless it contains in substance all of the applicable provisions required by sections 41-1904 to 41-1915[, Idaho Code], inclusive, of this chapter. This section shall not apply to annuity contracts nor to any provision of a life insurance policy, or contract supplemental thereto, relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(2) Any of such provisions or portions thereof not applicable to single premium or term policies shall to that extent not be incorporated therein.

History.

1961, ch. 330, § 434, p. 645.

STATUTORY NOTES

Cross References.

Simultaneous death of insured and beneficiary, distribution of proceeds of policy, § 15-2-613.

Compiler's Notes.

The bracketed insertion near the end of the first sentence in subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-1904. Grace period. — There shall be a provision that a grace period of thirty (30) days, or, at the option of the insurer, of one (1) month of not less than thirty (30) days, or of four (4) weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first policy year may be made, during which period of grace the policy shall continue in full force; the insurer may impose an interest charge not in excess of six per cent (6%) per annum for the number of days of grace elapsing before the payment of the premium, and, whether or not such interest charge is imposed, if a claim arises under the policy during such period of grace the amount of any premium due or overdue, together with interest and any deferred instalment of the annual premium, may be deducted from the policy proceeds.

History.

1961, ch. 330, § 435, p. 645.

§ 41-1905. Incontestability. — There shall be a provision that the policy (exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means) shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two (2) years from its date of issue.

History.

1961, ch. 330, § 436, p. 645.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law Contestability.

By former law, contestability was limited to two (2) years, but such law did not prohibit parties from contracting that period of contestability would be less than two (2) years nor from agreeing that policy would not be contestable after its delivery. *Duvall v. National Ins. Co.*, 28 Idaho 356, 154 P. 632 (1916).

Any defense on account of fraudulent warranties in application for insurance was precluded under clause making policy incontestable from date. *Duvall v. National Ins. Co.*, 28 Idaho 356, 154 P. 632 (1916).

§ 41-1906. Entire contract. — There shall be a provision that the policy, or the policy and the application therefor if a copy of such application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties, and that all statements contained in such an application shall, in the absence of fraud, be deemed representations and not warranties.

History.

1961, ch. 330, § 437, p. 645.

CASE NOTES

Cited *State v. Maybee*, 148 Idaho 520, 224 P.3d 1109 (2010).

Decisions Under Prior Law False Answers in Good Faith.

False answers in application, if made in good faith, would not void policy unless they had misled insurer to its injury. *Russell v. New York Life Ins. Co.*, 35 Idaho 774, 209 P. 273 (1922).

§ 41-1907. Misstatement of age. — There shall be a provision that if the age of the insured or of any other person whose age is considered in determining the premium or benefit has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

History.

1961, ch. 330, § 438, p. 645.

§ 41-1908. Dividends. — (1) There shall be a provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy provided the policy is in force and all premiums to that date are paid. Except as hereinafter provided, any dividend becoming payable shall at the option of the party entitled to elect such option be either:

(a) Payable in cash, or (b) Applied to any one of such other dividend options as may be provided by the policy. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if such party shall not have elected some other option. If the policy specifies a period within which such other dividend option may be elected, such period shall be not less than thirty (30) days following the date on which such dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning of (a) above even though the policy provides that payment of such dividend is to be deferred for a specified period, provided such period does not exceed six (6) years from the date of apportionment and that interest will be added to such dividend at a specified rate. If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under such nonforfeiture provision shall be applied in the manner set forth in the policy.

(2) In participating industrial life insurance policies, in lieu of the provision required in subsection (1) above, there shall be a provision that, beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus, if any, in the manner set forth in the policy.

History.

1961, ch. 330, § 439, p. 645.

§ 41-1909. Policy loan. — (1) There shall be a provision that after three (3) full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, an amount equal to or, at the option of the party entitled thereto, less than the loan value of the policy. A policy issued after July 1, 1975, and prior to July 1, 1982, shall contain either, but not both of the following policy loan interest rate provisions:

- (a) A provision that a policy loan shall bear interest at a specified rate (not exceeding eight per cent (8%) per annum); or
- (b) A provision that all loans under the policy, including outstanding loans, shall bear interest at a variable rate (not exceeding eight per cent (8%) per annum), specified from time to time by the insurer.

The effective date of any increase in such variable rate shall be not less than one (1) year after the effective date of the establishment of the previous rate. If the interest rate is increased, the amount of such increase shall not exceed one per cent (1%) per annum. The variable rate may be decreased without restriction as to amount or frequency. With respect to policies providing for a variable rate, the insurer shall, 1. when a loan is made and when notification of interest due is furnished, give notice of the variable rate currently effective; 2. as to any loans outstanding forty (40) days before the effective date of any increase in the variable rate, give notice of any such increase at least thirty (30) days before such effective date; and 3. as to any loans made during the forty (40) days before the effective date of the increase, give notice of such increase when the loan is made. Every such notice shall be given as directed by the policy owner and any assignee as shown on the records of the insurer at its home office.

(2)(a) Policies issued on or after July 1, 1982 shall provide for policy loan interest rates as follows: 1. A provision permitting a maximum interest rate of not more than eight per cent (8%) per annum; or

- 2. A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law.

(b) The rate of interest charged on a policy loan made under subsection (2)(a)2. shall not exceed the higher of the following: 1. The published monthly average for the calendar month ending two (2) months before the date on which the rate is determined; or 2. The rate used to compute the cash surrender values under the policy during the applicable period plus one per cent (1%) per annum.

(c) For purposes of this section the “published monthly average” means:

1. Moody’s Corporate Bond Yield Average — Monthly Average Corporates as published by Moody’s Investors Service, Inc. or any successor thereto; or 2. In the event that Moody’s Corporate Bond Yield Average — Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the director.

(d) If the maximum rate of interest is determined pursuant to subsection (2)(a)2., the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(e) The maximum rate for each policy must be determined at regular intervals at least once every twelve (12) months, but not more frequently than once in any three (3) month period. At the intervals specified in the policy: 1. The rate being charged may be increased whenever such increase as determined under subsection (2)(b) would increase that rate by one-half per cent (.5%) or more per annum; or 2. The rate being charged must be reduced whenever such reduction as determined under subsection (2)(b) would decrease that rate by one-half per cent (.5%) or more per annum.

(f) The life insurer shall:

1. Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan; 2. Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in (f)3. hereof; 3. Sent [Send] to policyholders with loans reasonable advance notice of any increase in the rate; and

4. Include in the notices required above the substance of the pertinent provisions of subsections (2)(a) and (2)(d).

(g) No policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(h) The substance of the pertinent provisions of subsections (2)(a) and (2)(d) shall be set forth in the policies to which they apply.

(i) For purposes of this section:

1. The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

2. The term “policy loan” includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due.

3. The term “policyholder” includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

4. The term “policy” includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(j) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

(k) The provisions of this section shall not apply to any insurance contract issued before July 1, 1981 unless the policyholder agrees in writing to the applicability of such provisions.

(3) The loan value of the policy shall be at least equal to the cash surrender value at the end of the then current policy year, provided that the insurer may deduct, either from such loan value or from the proceeds of the loan, any existing indebtedness not already deducted in determining such cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year, and any interest which may be allowable on the loan to the end of the current policy year.

The policy may also provide that if interest on any indebtedness is not paid when due it shall then be added to the existing indebtedness and shall bear interest at the same rate, and that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six (6) months after application therefor. The policy, at the insurer's option, may provide for automatic premium loan, subject to an election of the party entitled to elect.

(4) This section shall not apply to term policies nor to term insurance benefits provided by rider or supplemental policy provisions, or to industrial life insurance policies.

History.

1961, ch. 330, § 440, p. 645; am. 1975, ch. 232, § 1, p. 635; am. 1982, ch. 359, § 1, p. 908.

STATUTORY NOTES

Compiler's Notes.

For recent Moody's corporate average yields, see <http://naic.org/research/moody.htm>.

For Moody's Investors Service, Inc., see <http://www.moody.com>.

The bracketed word "Send" in paragraph (2)(f)3. was inserted by the compiler to correct the 1982 amendment of this section.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law

Constitutionality.

Provisions of former law which regulated and fixed rates of interest to be charged by life insurance companies doing business within the state, upon loans of money upon policy and forbearances in collection of dues upon

policy, did not violate provisions of constitution of this state or of United States, in that such provisions permitted the taking of property without due process of law. *Continental Life Ins. & Inv. Co. v. Hattabaugh*, 21 Idaho 285, 121 P. 81 (1912).

§ 41-1910. Table of installments. — In case the policy provides that the proceeds may be payable in installments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed installments.

History.

1961, ch. 330, § 441, p. 645.

§ 41-1911. Reinstatement. — There shall be a provision that unless:

(1) The policy has been surrendered for its cash surrender value, or (2) Its cash surrender value has been exhausted, or (3) The paid-up term insurance, if any, has expired, the policy will be reinstated at any time within three (3) years (or two (2) years in the case of industrial life insurance policies) from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears with interest at a rate not exceeding eight per cent (8%) per annum compounded annually and the payment or reinstatement of any other policy indebtedness with interest at a rate not exceeding the applicable policy loan rate or rates determined in accordance with the policy's provisions.

History.

1961, ch. 330, § 442, p. 645; am. 1993, ch. 185, § 1, p. 466.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law Reinstatement.

So far as the special reinstatement offer was concerned, the only conditions to reinstatement imposed were a certification by the insured that he was alive, and tender of the past-due premium with a request that it be accepted. These conditions were reasonably complied with and the policy must, therefore, be regarded as having been reinstated. *Sunset Life Ins. Co. of Am. v. Crosby*, 85 Idaho 407, 380 P.2d 9 (1963).

Within the limits of the terms and conditions of the original policy, upon application for reinstatement, the insurer may impose reasonable conditions as to insurability and require reasonably substantial compliance therewith. In acting upon an application for reinstatement, the insurer may not act

capriciously nor upon the basis of mere whim or fancy. *Sunset Life Ins. Co. of Am. v. Crosby*, 85 Idaho 407, 380 P.2d 9 (1963).

Idaho Code § 41-1912

§ 41-1912. Payment of premiums. — There shall be a provision relative to the payment of premiums.

History.

1961, ch. 330, § 443, p. 645.

§ 41-1913. Payment of claims. — There shall be a provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and, at the insurer's option, surrender of the policy and/or proof of the interest of the claimant. If an insurer shall specify a particular period prior to the expiration of which settlement shall be made, such period shall not exceed two (2) months from the receipt of such proofs.

History.

1961, ch. 330, § 444, p. 645.

§ 41-1914. Beneficiary — Industrial policies. — An industrial life insurance policy shall have the name of the beneficiary designated thereon with a reservation of the right to designate or change the beneficiary after the issuance of the policy. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. The policy may also provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than thirty (30) days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured. The policy may also include a similar provision applicable to any other payment due under the policy.

History.

1961, ch. 330, § 446, p. 645.

Idaho Code § 41-1915

§ 41-1915. Title. — There shall be a title on the policy, briefly describing the same.

History.

1961, ch. 330, § 446, p. 645.

§ 41-1916. Excluded or restricted coverage. — A clause in any policy of life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause.

History.

1961, ch. 330, § 447, p. 645.

§ 41-1917. Standard provisions — Annuity and pure endowment contracts. — (1) No annuity or pure endowment contract, other than reversionary annuities (also called survivorship annuities) or group annuities and except as stated herein, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in sections 41-1918 to 41-1923[, Idaho Code], inclusive, of this chapter. Any of such provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

(2) This section shall not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies.

History.

1961, ch. 330, § 448, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of the first sentence in subsection (1) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1918. Grace period — Annuities. — In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that there shall be a period of grace of one month, but not less than thirty (30) days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding six per cent (6%) per annum for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force; but in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

History.

1961, ch. 330, § 449, p. 645.

§ 41-1919. Incontestability — Annuities. — If any statements, other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to section 41-1921[, Idaho Code] of this chapter, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two (2) years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means.

History.

1961, ch. 330, § 450, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the middle of the section was added by the compiler to conform to the statutory citation style.

§ 41-1920. Entire contract — Annuities. — In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

History.

1961, ch. 330, § 451, p. 645.

§ 41-1921. Misstatement of age or sex — Annuities. — In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof with interest at the rate to be specified in the contract but not exceeding six per cent (6%) per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

History.

1961, ch. 330, § 452, p. 645.

§ 41-1922. Dividends — Annuities. — If an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

History.

1961, ch. 330, § 453, p. 645.

§ 41-1923. Reinstatement — Annuities. — In an annuity or pure endowment contract, other than a reversionary or group annuity, there shall be a provision that the contract may be reinstated at any time within one year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding six per cent (6%) per annum payable annually, and in cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

History.

1961, ch. 330, § 454, p. 645.

CASE NOTES

Decisions Under Prior Law Reinstatement.

So far as the special reinstatement offer was concerned, the only conditions to reinstatement imposed were a certification by the insured that he was alive, and tender of the past-due premium with a request that it be accepted. These conditions were reasonably complied with and the policy must, therefore, be regarded as having been reinstated. *Sunset Life Ins. Co. of Am. v. Crosby*, 85 Idaho 407, 380 P.2d 9 (1963).

Within the limits of the terms and conditions of the original policy, upon application for reinstatement, the insurer may impose reasonable conditions as to insurability and require reasonably substantial compliance therewith. In acting upon an application for reinstatement, the insurer may not act capriciously nor upon the basis of mere whim or fancy. *Sunset Life Ins. Co. of Am. v. Crosby*, 85 Idaho 407, 380 P.2d 9 (1963).

§ 41-1924. Standard provisions — Reversionary annuities. — (1) Except as stated herein, no contract for a reversionary annuity shall be delivered or issued for delivery in this state unless it contains in substance each of the following provisions:

(a) Any such reversionary annuity contract shall contain the provisions specified in sections 41-1918 through 41-1922[, Idaho Code,] except that under section 41-1918[, Idaho Code,] the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment in lieu of providing for deduction of such payments from an amount payable upon settlement under the contract.

(b) In such reversionary annuity contracts there shall be a provision that the contract may be reinstated at any time within three years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract be paid, or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding six per cent (6%) per annum compounded annually.

(2) This section shall not apply to group annuities or to annuities included in life insurance policies, and any of such provisions not applicable to single premium annuities shall not to that extent be incorporated therein.

History.

1961, ch. 330, § 455, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in paragraph (1)(a) were added by the compiler to conform to the statutory citation style.

§ 41-1925. Limitation of liability. — (1) No policy of life insurance shall be delivered or issued for delivery in this state if it contains any of the following provisions:

(a) A provision for a period shorter than that provided by statute within which an action at law or in equity may be commenced on such a policy.

(b) A provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one or more of the following circumstances: (i) Death as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces, or of any act or hazard of such war or action, or of service in the military, naval, or air forces or in civilian forces auxiliary thereto, or from any cause while a member of such military, naval, or air forces of any country at war, declared or undeclared, or of any country engaged in such military action; (ii) Death as a result of aviation or any air travel or flight; (iii) Death as a result of a specified hazardous occupation or occupations; (iv) Death while the insured is a resident outside continental United States and Canada; or (v) Death within two (2) years from the date of issue of the policy as a result of suicide, while sane or insane.

(2) A policy which contains any exclusion or restriction pursuant to subsection (1) of this section shall also provide that in the event of death under the circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the commissioners reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits (or if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy) with adjustment for indebtedness or dividend credit.

(3) This section shall not apply to group life insurance, disability insurance, reinsurance, or annuities, or to any provision in a life insurance

policy or contract supplemental thereto relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(4) Nothing contained in this section shall prohibit any provision which in the opinion of the director is more favorable to the policyholder than a provision permitted by this section.

History.

1961, ch. 330, § 456, p. 645.

STATUTORY NOTES

Cross References.

Commissioners reserve valuation method, § 41-612(5).

Compiler's Notes.

In subsection (4), “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Cited *Nielsen v. Provident Life & Accident Ins. Co.*, 100 Idaho 223, 596 P.2d 95 (1979).

Decisions Under Prior Law

Settlements at Maturity.

An option in a life insurance policy which permitted the insured to make a settlement with the insurance company under which he was paid an annuity with a guaranteed quarterly payment of \$157.55 for a period of ten (10) years and for as long thereafter as insured might live was not contrary to provision of former law prohibiting a settlement at the maturity of the policy for “less value than the amount insured on the face of the policy plus dividends,” since the insured was not required to take the annuity and could request the payment of the face amount plus dividends in cash. *Fox v. Northwestern Mut. Life Ins. Co.*, 136 F. Supp. 766 (D. Idaho 1956).

§ 41-1926. Prohibited provisions — Industrial life insurance. — No policy of industrial life insurance shall contain any of the following provisions:

(1) A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer.

(2) A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within two years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk.

(3) A provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless such right be conditioned upon a showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract.

History.

1961, ch. 330, § 457, p. 645.

§ 41-1927. Standard nonforfeiture law — Life insurance. —

(1)(a) This section shall be known as the standard nonforfeiture law for life insurance.

(b) “Operative date of the valuation manual” means January 1 of the first calendar year that the valuation manual, as defined in [section 41-612, Idaho Code](#), is effective.

(2) Nonforfeiture provisions: In the case of policies issued on or after the operative date of this section as defined in subsection (14) of this section, no policy of life insurance, except as set forth in subsection (13) of this section, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the director are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with subsection (12) of this law:

(a) That in the event of default in any premium payment, the insurer will grant, upon proper request not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(b) That upon surrender of the policy within sixty (60) days after the due date of any premium payment in default after premiums have been paid for at least three (3) full years in the case of ordinary insurance, and five (5) full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty (60) days after the due date of the premium in default.

(d) That if the policy shall have become paid up by completion of all premium payments, or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance, or the fifth policy anniversary in the case of industrial insurance, the insurer will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(e) In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary, either during the first twenty (20) policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of this state; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the

policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

(3) Any of the provisions or portions thereof set forth in subdivisions (a) through (f) of the foregoing subsection (2) which are not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy. The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor with surrender of the policy. If the insurer defers payment of a cash surrender value under the provisions of this section, the insurer shall pay interest to the policyholder at the rate specified in [section 28-22-104\(2\), Idaho Code](#), as established and in existence at the time of the surrender demand.

(4) Cash surrender value: Any cash surrender value available under the policy in the event of default in the premium payment due on any policy anniversary, whether or not required by subsection (2) of this section, shall be an amount not less than the excess, if any, of the present value on such anniversary of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions if there had been no default, over the sum of:

(a) The then present value of the adjusted premiums as defined in subsections (6) through (9) of this section, corresponding to premiums which would have fallen due on and after such anniversary, and

(b) The amount of any indebtedness to the insurer on account of or secured by the policy. Provided, however, that for any policy issued on or after the operative date of subsection (9)(d) as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such

paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision. Provided, further, that for any family policy issued on or after the operative date of subsection (9)(d) as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one (71), the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid up by completion of all premium payments, or any policy continued under any paid-up nonforfeiture benefits, whether or not required by such subsection (2), shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on account of or secured by the policy.

(5) Paid-up nonforfeiture benefits: Any paid-up nonforfeiture benefit available under the policy in the event of default in the premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy, or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the conditions that premiums shall have been paid for at least a specified period.

(6) The adjusted premium: This subsection shall not apply to policies issued on or after the operative date of subsection (9)(d) as defined therein. Except as provided in subsection (8) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding extra premiums on a substandard policy, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(a) The then present value of the future guaranteed benefits provided for by the policy;

(b) Two per cent (2%) of the amount of the insurance if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with the duration of the policy;

(c) Forty per cent (40%) of the adjusted premium for the first policy year;

(d) Twenty-five per cent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less, provided, however, that in applying the percentages specified in subdivisions (c) and (d) above, no adjusted premiums shall be deemed to exceed four per cent (4%) of the amount of insurance or uniform amount equivalent thereto. Whenever the plan or term of a policy has been changed, either by request of the insured or automatically in accordance with the provisions of the policy, the date of issue of the changed policy for the purposes of determining a nonforfeiture benefit or cash surrender value shall be the date as of which the age of the insured is determined for the purposes of the changed policy. The date of issue of a policy for the purposes of this subsection shall be the date as of which the rated age of the insured is determined.

(7) In the case of a policy providing an amount of insurance varying with the duration of the policy, the equivalent uniform amount thereof for the purpose of the preceding subsection (6) shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy, provided, however, that in the case of a policy for a varying amount of insurance issued on the life of a child under age ten (10), the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten (10) were the amount provided by such policy at age ten (10).

(8) The adjusted premiums for any policy providing term insurance benefits by any rider or supplemental policy provision shall be equal to (a)

the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in subsections (6) and (7) except that, for the purposes of subdivisions (b), (c) and (d) of subsection (6), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (4)(a).

(9)(a) Except as provided in subdivisions (b), (c) and (d) of this subsection, all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the commissioners 1941 standard ordinary mortality table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated, at the option of the insurer according to an age not more than three (3) years younger than the actual age of the insured and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 standard industrial mortality table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half per cent ($3\frac{1}{2}\%$) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred thirty per cent (130%) of the rates of mortality according to such applicable table, provided further that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director.

(b) This subsection (9)(b) shall not apply to ordinary policies issued on or after the operative date of subsection (9)(d) as defined therein. In the case of ordinary policies issued on or after the operative date of this subdivision as defined herein, all adjusted premiums and present values

referred to in this section shall be calculated on the basis of the commissioners' 1958 standard ordinary mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that such rate of interest shall not exceed three and one-half per cent (3 ½%) per annum except that a rate of interest not exceeding four per cent (4%) per annum may be used for policies issued on or after July 1, 1973, and prior to July 1, 1977, and a rate of interest not exceeding five and one-half per cent (5 ½%) per annum may be used for policies issued on or after July 1, 1977, except that for any single premium whole life or endowment insurance policy at a rate of interest not exceeding six and one-half per cent (6 ½%) per annum may be used and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners' 1958 extended term insurance table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director.

On or after the operative date of this section as defined in subsection (14) of this section, any insurer may file with the director a written notice of its election to comply with the provisions of this subdivision after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of this subdivision for such insurer), this subdivision shall become operative with respect to the ordinary policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subdivision for such insurer shall be January 1, 1966.

(c) This subsection (9)(c) shall not apply to industrial policies issued on or after the operative date of subsection (9)(d) as defined therein. In the case of industrial policies issued on or after the operative date of this subdivision as defined herein, all adjusted premiums and present values

referred to in this section shall be calculated on the basis of the commissioners' 1961 standard industrial mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half per cent (3 ½%) per annum except that a rate of interest not exceeding four per cent (4%) per annum may be used for policies issued on or after July 1, 1973, and prior to July 1, 1977, and a rate of interest not exceeding five and one-half per cent (5 ½%) per annum may be used for policies issued on or after July 1, 1977, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half per cent (6 ½%) per annum may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners' 1961 industrial extended term insurance table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director.

After the effective date of this amendatory act, any insurer may file with the director a written notice of its election to comply with the provisions of this subdivision after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of this subdivision for such insurer), this subdivision shall become operative with respect to the industrial policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this subdivision for such insurer shall be January 1, 1968.

(d)(i) Subsection (9)(d) shall apply to all policies issued on or after the operative date of this subsection (9)(d) as defined herein. Except as provided in paragraph vii of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a

statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (A) the then present value of the future guaranteed benefits provided for by the policy; (B) one per cent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and (C) one hundred twenty-five per cent (125%) of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (C) above, no nonforfeiture net level premium shall be deemed to exceed four per cent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(ii) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(iii) In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(iv) Except as otherwise provided in paragraph vii of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in

the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of the sum of (A) the then present value of the then future guaranteed benefits provided for by the policy and (B) the additional expense allowance, if any, over the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(v) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (A) one per cent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (B) one hundred twenty-five per cent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(vi) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where

(A) equals the sum of

1. the nonforfeiture net level premium applicable prior to the change, times the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and
2. the present value of the increase in future guaranteed benefits provided for by the policy, and

(B) equals the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(vii) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values, for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(viii) All adjusted premiums and present values referred to in this section shall, for all policies of ordinary insurance, be calculated on the basis of (A) the commissioners 1980 standard ordinary mortality table or (B) at the election of the insurer for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; shall, for all policies of industrial insurance, be calculated on the basis of the commissioners 1961 standard industrial mortality table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection, for policies issued in that calendar year. Provided, however, that:

1. At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.
2. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (2) shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.
3. An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the

policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

4. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioners 1961 industrial extended term insurance table for policies of industrial insurance.

5. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

6.(A) For policies issued prior to the operative date of the valuation manual, any commissioners standard ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the director for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioners 1980 extended term insurance table.

(B) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioners 1980 extended term insurance table. If the director approves by regulation any commissioners standard ordinary mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

7.(A) For policies issued prior to the operative date of the valuation manual, any commissioners standard industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table.

(B) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table. If the director approves by regulation any commissioners standard industrial mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(ix) The nonforfeiture interest rate is defined below:

1. For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent (125%) of the interest rate used in determining the minimum standard for the valuation of such policy as defined in the standard valuation law, rounded to the nearer one-quarter of one percent ($\frac{1}{4}$ of 1%).

2. For policies issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(x) Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation

for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refileing of any other provisions of that policy form.

(xi) After the effective date of subsection (9)(d), any insurer may file with the director a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such insurer. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1989.

(10) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on the then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsections (2) through (9) herein, then:

(a) The director must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsections (2) through (9) herein;

(b) The director must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(c) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this standard nonforfeiture law for life insurance, as determined by regulations promulgated by the director.

(11) Calculation of values: Any cash surrender value and any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (4) through (9) of this section may be

calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of subsection (4) of this section, additional benefits payable:

- (a) In the event of death or dismemberment by accident or accidental means,
- (b) In the event of total and permanent disability,
- (c) As reversionary annuity or deferred reversionary annuity benefits,
- (d) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply,
- (e) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six (26), is uniform in amount after the child's age is one (1), and has not become paid-up by reason of the death of a parent of the child, and
- (f) As other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(12) This subsection, in addition to all other applicable subsections of this section, shall apply to all policies issued on or after January 1, 1986. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one per cent ($2/10$ of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of:

- (a) The greater of zero and the basic cash value hereinafter specified; and
- (b) The present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (4) or (8), whichever is applicable, shall be the same as are the effects specified in subsection (4) or (8), whichever is applicable, on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (6) or (9)(d), whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

- (a) Must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one per cent ($\frac{2}{10}$ of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and
- (b) Must be such that no percentage after the later of the two (2) policy anniversaries specified in the preceding paragraph (a) may apply to fewer than five (5) consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (6) or (9)(d), whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall, for a particular policy, be calculated on the same mortality and interest basis as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in

this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (2), (3), (4), (5), (9)(d) and (11). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (a) through (f) in subsection (11) shall conform with the principles of this subsection (12).

(13) Exceptions. This section shall not apply to any of the following:

(a) Reinsurance,

(b) Group insurance,

(c) Variable life insurance,

(d) Pure endowment,

(e) Annuity or reversionary annuity contract,

(f) Term policy of uniform amount which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy,

(g) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (6) through (9) of this section, is less than the adjusted premiums so calculated on a policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy;

(h) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of

any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (4) through (9) of this section, exceeds two and one-half per cent (2 ½%) of the amount of insurance at the beginning of the same policy year;

(i) Policy which shall be delivered outside this state through an agent or other representative of the insurer issuing the policy.

For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(14) Operative date. After January 1, 1962, any insurer may file with the director a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1963. After the filing of such notice, then upon such specified date (which shall be the operative date for such insurer) this section shall become operative with respect to the policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this section for such insurer shall be January 1, 1963.

History.

1961, ch. 330, § 458, p. 645; am. 1965, ch. 307, § 2, p. 822; am. 1973, ch. 274, § 2, p. 574; am. 1977, ch. 265, § 2, p. 773; am. 1982, ch. 205, § 2, p. 543; am. 1989, ch. 142, § 1, p. 331; am. 2016, ch. 68, § 2, p. 205.

STATUTORY NOTES

Cross References.

Exemption from execution, proceeds of life insurance, § 11-604.

Standard valuation law, life insurance, § 41-612.

Amendments.

The 2016 amendment, by ch. 68, added the (1)(a) designation and added (1)(b); added the paragraph (9)(d)(viii)6.(A) designation, and added paragraph (9)(d)(viii)6.(B); added the paragraph (9)(d)(viii)7.(A) designation, and added paragraph (9)(d)(viii)7.(B); substituted “For policies issued prior to the operative date of the valuation manual, any commissioners standard” for “Any” at the beginning of paragraphs (9)(d)

(viii)6.(A) and (9)(d)(viii)7.(A); and added the paragraph (9)(d)(ix)1. designation and added paragraph (9)(d)(ix)2.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

As to national association of insurance commissioners, referred to in paragraphs (9)(d)(viii)6 and (9)(d)(viii)7, see *<http://www.naic.org>*.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1927A. Standard nonforfeiture law for individual deferred annuities. — (1) This section shall be known as the standard nonforfeiture law for individual deferred annuities.

(2) This section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under [section 408 of the Internal Revenue Code](#), as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the insurer issuing the contract.

(3) In the case of contracts issued on or after the operative date of this section as defined in subsection (12) of this section, no contract of annuity, except as stated in subsection (2) of this section shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the director are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract.

(a) That upon cessation of payment of considerations under a contract, the insurer will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (5), (6), (7), (8) and (10) of this section.

(b) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in subsections (5), (6), (8) and (10) of this section. The insurer shall reserve the right to defer the payment of such cash surrender benefit for a period of six (6) months after demand therefor with surrender of the contract. If the insurer defers payment of a cash surrender benefit under

this section, the insurer shall pay interest at the rate specified in [section 28-22-104\(2\), Idaho Code](#), as established and in existence at the time of the surrender demand.

(c) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits.

(d) A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract or any prior withdrawals from or partial surrenders of the contract.

Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars (\$20.00) monthly, the insurer may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

(4) The minimum values as specified in subsections (5), (6), (7), (8) and (10) of this section of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(a) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as indicated in subsection (4)(b) of this section of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of subparagraphs (4)(a)(i) through (iv) below:

- (i) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in subsection (4)(b) of this section;
- (ii) An annual contract charge of fifty dollars (\$50.00), accumulated at rates of interest as indicated in subsection (4)(b) of this section;
- (iii) Any premium tax paid by the insurer for the contract, accumulated at rates of interest as indicated in subsection (4)(b) of this section, provided that the premium tax credit is only permitted if the tax is actually paid by the insurer, and provided further that if the tax is paid and subsequently credited back to the insurer, such as upon early termination of the contract, the tax credit may not be taken; and
- (iv) The amount of any indebtedness to the insurer on the contract, including interest due and accrued.

The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of the gross considerations credited to the contract during that contract year.

(b) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:

- (i) The five (5) year constant maturity treasury rate reported by the federal reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one percent (.2%), specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under subsection (4)(b)(iv) of this section;
- (ii) Reduced by one hundred twenty-five (125) basis points;
- (iii) Where the resulting interest rate is not less than one percent (1%); and
- (iv) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five

(5) year constant maturity treasury rate to be used at each redetermination date.

(c) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subsection (4)(b)(ii) of this section by up to an additional one hundred (100) basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The director may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the director, the director may disallow or limit the additional reduction.

(d) The director may adopt rules to implement the provisions of subsection (4)(c) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the director determines adjustments are justified.

(5) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(6) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the insurer on the contract, including interest

due and accrued, and increased by any existing additional amounts credited by the insurer to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(7) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the insurer to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(8) For the purpose of determining the benefits calculated under subsections (6) and (7) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(9) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(10) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with

fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(11) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of subsections (5), (6), (7), (8) and (10) of this section, additional benefits payable (i) in the event of total and permanent disability, (ii) as reversionary annuity or deferred reversionary annuity benefits, or (iii) as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

(12) After the effective date of this section any insurer may file with the director a written notice of its election to comply with the provisions of this section after a specified date before the second anniversary of the effective date of this section. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for such insurer, this section shall become operative with respect to annuity contracts thereafter issued by such insurer. If an insurer makes no such election, the operative date of this section for such insurer shall be the second anniversary of the effective date of this section.

History.

I.C., § 41-1927A, as added by 1977, ch. 265, § 3, p. 773; am. 1989, ch. 142, § 2, p. 331; am. 2003, ch. 86, § 1, p. 261; am. 2004, ch. 92, § 1, p. 332.

STATUTORY NOTES

Federal References.

Section 408 of the Internal Revenue Code, referred to in subsection (2) of this section, is compiled as 26 U.S.C.S. § 408.

Compiler's Notes.

The phrase “the effective date of this section” in subsection (12) refers to the effective date of the enacting legislation for this section, S.L. 1977, Chapter 265, which was effective July 1, 1977.

The words enclosed in parentheses so appeared in the law as enacted.

Section 2 of S.L. 2004, ch. 92 provides: “Before January 1, 2006, an insurer may (1) issue an annuity policy under the provisions of Section 41-1927A(4), Idaho Code, as those provisions were in effect on July 1, 2003; or (2) issue an annuity policy under the provisions of Section 41-1927A(4), Idaho Code, as those provisions are in effect on July 1, 2004. On and after January 1, 2006, an annuity policy issued by an insurer must comply with the provisions of Section 41-1927A(4), Idaho Code, as those provisions, including any subsequent amendments thereto, are in effect on and after July 1, 2004.”

§ 41-1928. Nonforfeiture benefits — Certain interim policies. — (1) Each life insurance policy issued between the effective date of this code and the operative date of section 41-1927[, Idaho Code] (standard nonforfeiture law) shall contain:

(a) An automatic nonforfeiture provision, which must be either a loan, a paid-up policy, or an extended term, to which the policyholder is entitled in the event of default in a premium payment after three (3) full annual premiums shall have been paid.

(b) Tables showing in figures the cash, paid-up and extended insurance options available under the policy each year upon default in premium payments, during the first twenty (20) years of the policy, or for its life if maturity is less than twenty (20) years.

(c) At the insurer's option, a provision that the insurer shall have the right to defer payment of the cash value for a period not exceeding six (6) months.

(2) The value of the options referred to in subdivision (b) above, shall be equivalents based on the reserves which shall be computed according to the tables of mortality and rate of interest named in the policy, and according to a basis and method of valuation acceptable under section 41-612(3)[, Idaho Code] (standard valuation law), less a specified surrender charge, not exceeding two and one-half percent (2 ½%) of the amount of insurance. Provided, however, that if the benefits under the policy are calculated according to a more modern table than the American experience table of mortality, the value of any extended term insurance, with accompanying pure endowment, if any, may be calculated according to rates of mortality not exceeding one hundred thirty percent (130%) of the rates according to such more modern table.

(3) Any of the foregoing provisions or portions thereof not applicable to single premium or term policies need not to that extent be incorporated therein. This section shall not apply to industrial insurance, annuities, pure endowments with or without return premium, and policies of reinsurance.

History.

1961, ch. 330, § 459, p. 645.

STATUTORY NOTES

Compiler's Notes.

The phrase “the effective date of this code” in the first paragraph refers to the effective date of S.L. 1961, Chapter 330, which was January 1, 1962.

For “the operative date of section 41-1927,” referred to in the introductory paragraph of subsection (1), see subsection (12) of that section.

The bracketed insertions in the introductory paragraph in subsection (1) and near the beginning of subsection (2) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law

Tables Showing Insurance Options.

Requirement of former law that life insurance policy shall contain as a part of the policy a table, etc., was not an unfair or unreasonable requirement and could have been enforced by insurance commissioner. [*Continental Life Ins. & Inv. Co. v. Hattabaugh*, 21 Idaho 285, 121 P. 81 \(1912\).](#)

§ 41-1929. Incontestability and limitation of liability after reinstatement. — (1) A reinstated policy of life insurance or annuity contract may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

(2) When any life insurance policy or annuity contract is reinstated, such reinstated policy or contract may exclude or restrict liability to the same extent that such liability could have been or was excluded or restricted when the policy or contract was originally issued, and such exclusion or restriction shall be effective from the date of reinstatement.

History.

1961, ch. 330, § 460, p. 645.

§ 41-1930. Policy settlements. — Any life insurer shall have the power to hold under agreement the proceeds of any policy issued by it, upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries, and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as set forth in the policy or as agreed to in writing by the insurer and the policyholder. Upon maturity of a policy, in the event the policyholder has made no such agreement, the insurer shall have the power to hold the proceeds of the policy under an agreement with the beneficiaries. The insurer shall not be required to segregate the funds so held but may hold them as part of its general assets.

History.

1961, ch. 330, § 461, p. 645.

§ 41-1931. Indebtedness deducted from proceeds. — In determining the amount due under any life insurance policy heretofore or hereafter issued, deduction may be made of:

(1) Any unpaid premiums or installments thereof for the current policy year due under the terms of the policy, and of

(2) The amount of principal and accrued interest of any policy loan or other indebtedness against the policy then remaining unpaid.

History.

1961, ch. 330, § 462, p. 645.

§ 41-1932. Participating and nonparticipating policies — Right to issue. — A life insurer may issue policies on either the participating basis or the nonparticipating basis, or on both bases, if the right or absence of right of participation is reasonably related to the premium charged and the insurer is otherwise not in violation of sections 41-1313[, Idaho Code] (unfair discrimination — life insurance, annuities, and disability insurance) or 41-1314[, Idaho Code] (rebates, illegal inducements).

History.

1961, ch. 330, § 463, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions near the end of the section were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1933. Participating and nonparticipating policies — Accounting.

— (1) A life insurer issuing both participating and nonparticipating policies shall maintain a system of accounting which segregates the participating from the nonparticipating business and clearly shows the profits and losses upon each such category of business. The insurer's annual statement as filed with the director under section 41-335[, Idaho Code,] shall provide such information with respect to such categories as is called for in connection therewith.

(2) For the purposes of such accounting the insurer shall make a reasonable allocation as between the respective such categories of the expenses of such general operations or functions as are jointly shared. Any allocation of expense as between the respective categories shall be made upon a reasonable basis, to the end that each category shall bear a just portion of joint expense involved in the administration of the business of such category.

(3) No policy hereafter shall provide for, and no life insurer or representative shall hereafter knowingly offer or promise payment, credit, or distribution of participating “dividends”, “earnings”, “profits” or “savings”, by whatever name called, to participating policies out of such profits, earnings or savings on nonparticipating policies. This provision shall not be deemed to restrict the generality of section 41-1314[, Idaho Code] (rebates, illegal inducements).

History.

1961, ch. 330, § 464, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in the last sentences in subsections (1) and (3) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1934. Prohibited policy plans. — (1) No life insurer shall hereafter deliver or issue for delivery in this state:

(a) As part of or in combination with any life insurance, endowment or annuity contract, any agreement or plan, additional to the rights, dividends, and benefits arising out of any such contract, which provides for the accumulation of profits over a period of years and for payment of all or any part of such accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified or ascertainable period of years.

(b) Any individual life insurance policy which provides that on the death of anyone other than a beneficiary or a person insured thereunder, the owner or beneficiary of the policy shall receive the payment or granting of anything of value.

(c) Any “registered” policy; that is, any policy purporting to be “registered” or otherwise specially recorded, with any agency of the state of Idaho, or of any other state or with any bank, trust company, escrow company, or other institution other than the insurer; or purporting that any reserves, assets or deposits are held, or will be so held, for the special benefit or protection of the holder of such policy, by or through any such agency or institution.

(d) Any policy or contract under which any part of the premium or of funds or values arising from the policy or contract or from investment of reserves, or from mortality savings, lapses or surrenders, in excess of the normal reserves or amounts required to pay death, endowment, and nonforfeiture benefits in respective amounts as specified in or pursuant to the policy or contract, are on a basis not involving insurance or life contingency features, (i) to be placed in special funds or segregated accounts or specially designated places or (ii) to be invested in specially designated investments or types thereof, and the funds or earnings thereon to be divided among the holders of such policies or contracts, or their beneficiaries or assignees. This subdivision (d) does not apply as to variable life insurance or variable annuity contracts issued under [section 41-1936, Idaho Code](#).

(e) Any profit sharing, charter, coupon or founders policy.

(f) For the purposes of subdivision (e) above, a “profit sharing” policy is:

(i) A life insurance policy which by its terms expressly provides that the policyholder will participate in the distribution of earnings or surplus other than earnings or surplus attributable, by reasonable and nondiscriminatory standards, to the participating policies of the insurer and allocated to the policyholder on reasonable and nondiscriminatory standards; or

(ii) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the insurer to prospective policyholders as entitling the policyholder to the benefits described in paragraph (i) of this subdivision (f).

(g) For the purposes of subdivision (e) above a “charter” or “founders” policy is:

(i) A life insurance policy which by its terms expressly provides that the policyholder will receive some preferential or discriminatory advantage or benefit not available to persons who purchase insurance from the insurer at future dates or under other circumstances; or

(ii) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the insurer to prospective policyholders as entitling the policyholders to the benefits described in subdivision (g)(i) of this section.

(h) For the purposes of subdivision (e) above, a “coupon” policy means a life insurance policy which provides a series of pure endowments maturing periodically in amounts not exceeding the gross annual policy premiums. The term “pure endowment” or “endowment” is used in its accepted actuarial sense, meaning a benefit becoming payable at a specific future date if the insured person is then living.

(2) This section shall not be deemed to prohibit the provision, payment, allowance or apportionment of regular annual dividends or “savings” under regular participating forms of policies or contracts.

History.

1961, ch. 330, § 465, p. 645; am. 1969, ch. 214, § 50, p. 625; am. 1972, ch. 369, § 10, p. 1072.

§ 41-1935. Life insurance and annuities — Twenty day free examination. — (1) Every life insurance policy to which the provisions of [section 41-1927, Idaho Code](#), apply and every annuity contract shall contain a provision therein or in a separate rider attached thereto when delivered, stating in substance that the person to whom the life insurance policy or annuity contract is issued shall be permitted to return the life insurance policy or annuity within twenty (20) days of its delivery to such person, and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. The provision shall be set forth in the policy or contract under appropriate caption, and if not so printed on the face page of the policy or contract adequate notice of the provision shall be printed or stamped conspicuously on the face page.

(2) The policy or contract may be so returned to the insurer at its home or branch office or to the agent through whom it was applied for, and thereupon shall be void as from the beginning and as if the policy or contract had not been issued.

History.

[I.C., § 41-1935](#), as added by 1992, ch. 162, § 1, p. 517.

STATUTORY NOTES

Prior Laws.

Former § 41-1935, which comprised S.L. 1965, ch. 291, § 1, was repealed by S.L. 1969, ch. 214, § 72.

§ 41-1936. Separate accounts — Operation and management. — (1)

A domestic life insurer may, by or pursuant to resolution of its board of directors, establish one or more separate accounts, and may allocate thereto amounts to provide for life insurance or annuities (and benefits incidental thereto), payable in fixed or in variable amounts or in both.

(2) The amounts allocated to each such account and accumulations thereon may be invested as provided in section 41-734[, Idaho Code] of this act (special investments of separate account funds).

(3) The income, if any, and gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account without regard to other income, gains or losses of the insurer.

(4) Unless otherwise approved by the director, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; except, that unless otherwise approved by the director, a portion of the assets of such separate account equal to the insurer's reserve liability with regard to the guaranteed benefits and funds, if any, referred to in [section 41-734, Idaho Code](#), (special investments of separate account funds), shall be valued in accordance with the rules otherwise applicable to the insurer's assets.

(5) Amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the insurer, and the insurer shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct.

(6) No sale, exchange or other transfer of assets may be made by an insurer between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to

establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (a) by a transfer of cash, or (b) by a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the director. The director may approve other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

(7) To the extent that the insurer deems it necessary to comply with any applicable federal or state laws, the insurer, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein, appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the insurer, to manage the business of such account.

History.

I.C., § 41-1936, as added by 1969, ch. 214, § 51, p. 625; am. 1971, ch. 272, § 2, p. 1078.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in subsection (2) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-1937. Variable contracts — Statement of essential features. —

(1) Any variable contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of such variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will so vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

(2) Variable annuity contracts delivered or issued for delivery in this state may include as an incidental benefit provision for payment on death during the deferred period of an amount not in excess of the greater of the sum of the premiums or stipulated payments paid under the contract or the value of the contract at time of death. Any such provision shall not be deemed to be life insurance and shall not be subject to the provisions of this code governing life insurance contracts. A provision for any other benefit on death during the deferred period shall be subject to such life insurance provisions.

History.

I.C., § 41-1937, as added by 1969, ch. 214, § 52, p. 625; am. 1971, ch. 272, § 3, p. 1078.

§ 41-1938. Variable contracts — Authority of insurer to issue. — No insurer shall deliver or issue for delivery in this state contracts authorized under [section 41-1936, Idaho Code](#), unless it is authorized or organized to do a life insurance or annuity business in this state, and the director is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the director shall consider among other things:

(1) The history and financial condition of the insurer; (2) The character, responsibility and fitness of the officers and directors of the insurer; and (3) The law and regulation under which the insurer is authorized in the state of domicile to issue variable contracts.

History.

[I.C., § 41-1938](#), as added by 1969, ch. 214, § 53, p. 625; am. 1999, ch. 95, § 1, p. 297.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1939. Variable contracts — Regulation thereof. — (1) Notwithstanding any other provision of law, the director shall have sole and exclusive authority to regulate the issuance and sale of variable contracts and to provide for licensing of persons selling such contracts, and to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of this section.

(2) The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(3) The director, by regulation, may require that any individual variable contract, delivered or issued for delivery in this state, shall contain provisions as to policy loans, payment of premiums, payment of claims, indebtedness and nonforfeiture benefits appropriate to a variable contract.

History.

I.C., § 41-1939, as added by 1969, ch. 214, § 54, p. 625.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-1940. Suitability of annuity sales to consumers. — (1) In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in an insurance transaction or a series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's age, financial situation and needs.

(2) Prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain information concerning:

- (a) The consumer's financial status;
- (b) The consumer's tax status;
- (c) The consumer's investment objectives; and
- (d) Such other information used or considered to be reasonable by the insurance producer, or the insurer where no producer is involved, in making recommendations to the consumer.

(3) Neither an insurance producer, nor an insurer where no producer is involved, shall have any obligation to a consumer under this section related to any recommendation if a consumer:

- (a) Refuses to provide relevant information requested by the insurer or insurance producer;
- (b) Decides to enter into an insurance transaction that is not based upon a recommendation of the insurer or insurance producer; or
- (c) Fails to provide complete and accurate information.

(4) This section shall not apply to recommendations involving:

- (a) Direct response solicitations where there is no recommendation based upon information collected from the consumer;

(b) Contracts used to fund employee retirement or benefit plans established or maintained by an employer;

(c) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(d) Contracts or transactions exempted pursuant to rules promulgated by the director, where the director has determined the protections of this law are not necessary.

(5) The director may promulgate rules pursuant to this section for the protection of consumers in annuity transactions.

(6) Nothing in this section shall be construed to create or imply a private cause of action for a violation of this section or rules promulgated pursuant to this section.

History.

I.C., § 41-1940, as added by 2005, ch. 76, § 1, p. 256; am. 2008, ch. 202, § 1, p. 650.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 202, in the section heading and throughout the section, deleted “senior” preceding “consumer”; and deleted subsection (2), which was the definition for “senior consumer,” and redesignated the subsequent subsections accordingly.

§ 41-1941. Annuity sales to consumers — Disclosures. — (1) In this section, the following definitions shall apply unless the context otherwise requires:

(a) “Contract owner” means the owner named in the annuity contract or certified holder in the case of a group annuity contract.

(b) “Determinable elements” means elements that are derived from processes or methods that are guaranteed at issue and that are not subject to company discretion, but where the values or amounts cannot be determined until some point after issue. These elements may include the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges or elements of formulas used to determine any of these. An element is considered determinable if it is calculated from underlying determinable elements only or from both determinable and guaranteed elements.

(c) “Generic name” means a short title descriptive of the annuity contract being applied for or illustrated such as “single premium deferred annuity.”

(d) “Guaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges or elements of formulas used to determine any of these that are promised and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

(e) “Insurance producer” or “producer” has the same meaning as in chapter 10, title 41, Idaho Code.

(f) “Nonguaranteed elements” means the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, charges or elements of formulas used to determine any of these that are subject to company discretion and that are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(g) “Structured settlement annuity” means a qualified funding asset as defined in [section 130\(d\) of the Internal Revenue Code](#) or an annuity that

would be a qualified funding asset under [section 130\(d\) of the Internal Revenue Code](#) but for the fact that it is not owned by an assignee under a qualified assignment.

(2) The provisions of this section shall apply to all group and individual annuity contracts and certificates except:

(a) Registered or nonregistered variable annuities or other registered products;

(b) Immediate and deferred annuities that contain no nonguaranteed elements;

(c) Annuities used to fund:

(i) An employee pension plan that is covered by the employee retirement income security act of 1974, title [29, U.S.C. 1001 through 1461](#);

(ii) A plan described in [section 401\(a\), 401\(k\) or 403\(b\) of the Internal Revenue Code](#), where the plan, for purposes of the employee retirement income security act of 1974, is established or maintained by an employer;

(iii) A governmental or church plan as defined in [section 414 of the Internal Revenue Code](#) or a deferred compensation plan of a state or local government or a tax-exempt organization pursuant to [section 457 of the Internal Revenue Code](#); or

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(d) Structured settlement annuities.

(3) If the application for an annuity contract is taken in a face-to-face meeting, the applicant, at or before the time of application and at the time of contract delivery, shall be given both the disclosure document and the buyer's guide in the form prescribed by the director. The disclosure document shall be dated and signed by the prospective annuity owner and producer and the company shall maintain a signed copy for a period of five (5) years after the natural life of the contract.

(4) If the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the buyer's guide at the time of application and at the time of contract delivery. The producer and the company shall maintain a signed copy of the disclosure document for a period of five (5) years after the natural life of the contract.

(5) A solicitation for an annuity contract provided in other than a face-to-face meeting shall include a statement that the proposed applicant may contact the insurer for a free annuity buyer's guide.

(6) At a minimum, the following information shall be included in the disclosure document required to be provided under this section in a form or forms prescribed by the director:

(a) The generic name of the contract, the company product name, if different, the form number and the fact that it is an annuity;

(b) The insurer's name and address;

(c) A description of the contract and its benefits, emphasizing its long-term nature and including the following examples where appropriate:

(i) The guaranteed, nonguaranteed and determinable elements of the contract, their limitations, if any, and an explanation of how they operate;

(ii) An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

(iii) The periodic income options both on a guaranteed and nonguaranteed basis;

(iv) Any value reductions caused by withdrawals from or surrender of the contract;

(v) How values in the contract can be accessed;

(vi) The death benefit, if available, and how it will be calculated;

(vii) A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

- (viii) The impact of any rider, such as a long-term care rider.
- (d) The specific dollar amount or percentage charges and fees shall be listed with an explanation of how they apply;
- (e) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change;
- (f) Whenever projections for nonguaranteed elements of a contract are provided in the disclosure document, equal prominence shall be given to guaranteed elements; and
- (g) Terms used in the disclosure document shall be defined in clear and concise language that facilitates the understanding of a typical person within the segment of the public to which the disclosure document is directed.

(7) For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract. Such report shall contain at a minimum the following information:

- (a) The beginning and end dates of the current report period;
- (b) The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;
- (c) The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and
- (d) The amount of outstanding loans, if any, as of the end of the current report period.

(8) The director may promulgate rules pursuant to this section including, but not limited to, more fully implementing model rules or laws developed by the national association of insurance commissioners that provide standards for the disclosure of certain minimum information in connection with the sale of annuity contracts.

(9) Nothing in this section shall be construed to create or imply a private cause of action for a violation of the provisions of this section or rules promulgated pursuant to this section.

History.

I.C., § 41-1941, as added by 2010, ch. 238, § 1, p. 617; am. 2012, ch. 107, § 6, p. 284; am. 2020, ch. 290, § 1, p. 837.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 107 inserted “or” in paragraph (8)(c).

The 2020 amendment, by ch. 290, in subsection (3), inserted “and at the time of contract deliver” near the middle of the first sentence and substituted “signed copy for a period of five (5) years after the natural life” for “the life” near the end of the last sentence; rewrote subsection (4), which formerly read: “If the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant shall be sent both the disclosure document and the buyer’s guide in the manner and form prescribed by the director no later than five (5) business days after the completed application is received by the insurer”; deleted former subsection (6), which read: “If the disclosure document and buyer’s guide are not provided at or before the time of application, a free look period of not less than twenty (20) days shall be provided for the applicant to return the annuity contract without penalty. This free look period shall run concurrently with any other free look period provided in statute”; redesignated former subsections (7) to (10) as subsections (6) to (9); and, in present subsection (6), inserted “in a form or forms prescribed by the director” at the end of the introductory paragraph.

Federal References.

Section 130(d) of the Internal Revenue Code, referred to in paragraph (1)(g), is codified as **26 USCS § 130(d)**.

Sections 401(a), 401(k) and 403(b) of the Internal Revenue Code, referred to in paragraph (2)(c)(ii), are codified as **26 USCS §§ 401(a), 401(k), and 403(b)**.

Sections 414 and 457 of the Internal Revenue Code, referred to in paragraph (2)(c)(iii), are codified as **26 USCS §§ 414 and 457**.

Compiler’s Notes.

For additional information on annuity contracts and the national association of insurance commissioners, see *<http://www.naic.org/ciprtopics/topicannuities.htm>*.

§ 41-1942. Advertisement of interest-indexed annuities. — No issuer of interest-issued [interest-indexed] annuity contracts shall advertise interest-indexed annuity contracts, regardless of the advertising medium, without prior approval of such advertisement from the director. For purposes of this section, “interest-indexed annuity” means a type of annuity whose credited interest is linked to an external reference at any time during the term of the contract and shall include contracts, application forms where written application is required and is to be made a part of the contract, printed riders, endorsements, and renewal certificates.

History.

I.C., § 41-1942, as added by 2020, ch. 290, § 2, p. 837.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertion near the beginning of the section was added by the compiler, at the request of the Idaho department of insurance and the Idaho compilation commission, to correct an obvious typographical error in the enacting legislation.

For additional information on annuities and the national association of insurance commissioners, see *[https://content.naic.org/cipr_topics/topic annuities.htm](https://content.naic.org/cipr_topics/topic_annuities.htm)*.

§ 41-1943. Standards for policy provisions for annuities. — No annuity shall be delivered or issued for delivery in this state that contains:

(1) Surrender charges that persist past ten (10) years from the time of deposit; or (2) Surrender charges that exceed ten percent (10%) in the first year and decrease one percent (1%) per year in subsequent years.

History.

I.C., § 41-1943, as added by 2020, ch. 290, § 3, p. 837.

STATUTORY NOTES

Compiler's Notes.

For additional information on annuities and the national association of insurance commissioners, see *[https://content.naic.org/cipr_topics/topic annuities.htm](https://content.naic.org/cipr_topics/topic_annuities.htm)*.

§ 41-1944 — 41-1949. [Reserved.]

§ 41-1950. Short title and scope. — (1) Sections 41-1950 through 41-1965, Idaho Code, may be cited as the “Life Settlements Act.”

(2) Nothing contained herein is intended to abrogate or conflict with the Idaho uniform securities act contained in chapter 14, title 30, Idaho Code, or supersede the duty of persons to comply with that or any other applicable law. Given the combined interest and regulation of life settlements by the department and the department of finance, the director and the director of the department of finance should cooperate in the exercise of discretionary acts and enforcement of the applicable laws within their respective authority and responsibility.

(3) Unless clearly inapplicable, other provisions and chapters of title 41, Idaho Code, apply to licensees and persons subject to sections 41-1950 through 41-1965, Idaho Code, including, but not limited to, chapters 1 through 5, 10, 13, 18 and 19, title 41, Idaho Code. Specifically, section 41-220, Idaho Code, applies to licensees under sections 41-1950 through 41-1965, Idaho Code.

History.

I.C., § 41-1950, as added by 2009, ch. 69, § 1, p. 192.

STATUTORY NOTES

Cross References.

Director of department of finance, § 67-2701 et seq.

§ 41-1951. Definitions. — In sections 41-1950 through 41-1965, Idaho Code:

(1) “Advertising” means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed directly before the public, in this state, for the purpose of creating an interest in or inducing a person to sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy pursuant to a life settlement contract.

(2) “Business of life settlements” means an activity involved in, but not limited to, the offering to enter into, soliciting, negotiating, procuring or effectuating a life settlement contract. The transaction of the business of life settlements is within the scope of the transaction of the business of insurance as provided in section 41-112, Idaho Code.

(3) “Chronically ill” means:

(a) Being unable to perform at least two (2) activities of daily living such as eating, toileting, transferring, bathing, dressing or continence; or

(b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(4) “Financing entity” means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a life settlement provider, credit enhancer or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract, but:

(a) Whose principal activity related to the transaction is providing funds to effect the life settlement or purchase of one (1) or more settled policies; and

(b) Who has an agreement in writing with one (1) or more licensed life settlement providers to finance the acquisition of life settlement contracts.

“Financing entity” does not include a nonaccredited investor. An “accredited investor” is defined by rule 501 of regulation D, [17 CFR 230.501\(a\)](#).

(5) “Life insurance producer” means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to [section 41-1008, Idaho Code](#).

(6) “Life settlement broker” or “broker” means a person who, working exclusively on behalf of an owner and for a fee, commission or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and one (1) or more life settlement providers or one (1) or more life settlement brokers. Notwithstanding the manner in which the life settlement broker is compensated, a life settlement broker is deemed to represent only the owner, and not the insurer or the life settlement provider, and owes a fiduciary duty to the owner to act according to the owner’s instructions and in the best interest of the owner. Nothing in this definition reduces or impairs the scope of the definitions in [section 30-14-102, Idaho Code](#), including, but not limited to, agent, broker-dealer, investment adviser, and investment adviser representative. The term does not include an attorney, certified public accountant or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the owner and whose compensation is not paid directly or indirectly by the life settlement provider or purchaser.

(7) “Life settlement contract” means an agreement between an owner and a life settlement provider or any affiliate, as that term is defined in [section 41-3802\(1\), Idaho Code](#), of the life settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the policy, in return for the owner’s present or future assignment, transfer, sale, hypothecation, devise or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. Nothing in this definition reduces or impairs the scope of the definition of security contained in [section 30-14-102\(28\), Idaho Code](#).

(a) “Life settlement contract” includes a premium finance loan made for a life insurance policy on or before the date of issuance of the policy where

one (1) or more of the following conditions apply:

- (i) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

- (ii) The owner or the insured receives on the date of the premium finance loan a guarantee of a future life settlement value of the policy; or

- (iii) The owner or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(b) “Life settlement contract” includes the transfer, for compensation or value, of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other person was formed or availed of for the principal purpose of acquiring one (1) or more life insurance policies which life insurance contract insures the life of a person residing in this state.

(c) “Life settlement contract” does not include any of the following:

- (i) A policy loan or accelerated death benefit made by the insurer pursuant to the policy’s terms;

- (ii) A loan, the proceeds of which are used solely to pay:

- (A) Premiums for the policy; and

- (B) The costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third party collateral provider fees and expenses, including fees payable to letter of credit issuers;

- (iii) A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, provided that neither the default itself nor the transfer of the policy in connection with the default is pursuant to an agreement or

understanding with any other person for the purpose of evading regulation under [sections 41-1950 through 41-1965, Idaho Code](#);

(iv) A loan made by a lender that does not violate the Idaho credit code, provided that the premium finance loan is not described in paragraph (a) of this subsection;

(v) An agreement where all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(vi) Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(vii) A bona fide business succession planning arrangement:

(A) Between one (1) or more shareholders in a corporation or between a corporation and one (1) or more of its shareholders or one (1) or more trusts established by its shareholders;

(B) Between one (1) or more partners in a partnership or between a partnership and one (1) or more of its partners or one (1) or more trusts established by its partners; or

(C) Between one (1) or more members in a limited liability company or between a limited liability company and one (1) or more of its members or one (1) or more trusts established by its members;

(viii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(ix) Any other contract, transaction or arrangement exempted from the definition of life settlement contract by the director based on a determination that the contract, transaction or arrangement is not of the type intended to be regulated by [sections 41-1950 through 41-1965, Idaho Code](#).

(8) “Life settlement provider” or “provider” means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner resident in this state. Nothing in this definition reduces or impairs the scope of the definitions of [section 30-14-102, Idaho Code](#), including, but not limited to, agent, broker-dealer, investment adviser, and investment adviser representative. “Life settlement provider” does not include:

- (a) A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan;
- (b) A premium finance company making premium finance loans that takes an assignment of a life insurance policy solely as collateral for a loan;
- (c) The insurer of the life insurance policy;
- (d) An authorized or eligible insurer that provides stop loss coverage or financial guaranty insurance to a life settlement provider, purchaser, financing entity, special purpose entity or related provider trust;
- (e) A financing entity;
- (f) A special purpose entity;
- (g) A related provider trust; or
- (h) Any other person that the director determines is not the type of person intended to be covered by the definition of life settlement provider.

(9) “Owner” means the owner of a life insurance policy or a certificate holder under a group policy who resides in this state and enters or seeks to enter into a life settlement contract. For the purposes of [sections 41-1950 through 41-1965, Idaho Code](#), an owner shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed.

- (a) If there is more than one (1) owner on a single policy and the owners are residents of different states, the transaction shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one (1) owner agreed upon in writing by all the owners.

(b) “Owner” does not include:

(i) A licensee under [sections 41-1950 through 41-1965, Idaho Code](#), including a life insurance producer acting as a life settlement broker pursuant to [sections 41-1950 through 41-1965, Idaho Code](#);

(ii) Qualified institutional buyer as defined, respectively, in rule 144A, [17 CFR 230.144A](#), promulgated under the federal securities act of 1933, [15 USC section 77a et seq.](#), as amended;

(iii) A financing entity;

(iv) A special purpose entity; or

(v) A related provider trust.

(10) “Policy” means an individual or group policy, group certificate, contract or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(11) “Premium finance loan” means a loan made primarily for the purpose of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

(12) “Related provider trust” means a titling trust or other trust established by a licensed life settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed life settlement provider under which the licensed life settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to life settlement transactions available to the director as if those records and files were maintained directly by the licensed life settlement provider.

(13) “Settled policy” means a life insurance policy or certificate that has been acquired by a life settlement provider pursuant to a life settlement contract.

(14) “Special purpose entity” means a corporation, partnership, trust, limited liability company or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:

- (a) For a financing entity or licensed life settlement provider;
- (b) In connection with a transaction in which the securities in the special purposes entity are acquired by the owner or by “qualified institutional buyers” as defined in rule 144A, [17 CFR 230.144A](#), promulgated under the federal securities act of 1933, as amended; or
- (c) In connection with a transaction in which the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(15) “Stranger-originated life insurance” or “STOLI” means an act, plan, practice, or arrangement to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person who, at the time of policy inception, could not lawfully initiate the policy himself or itself, and where, at the time of inception, there is an arrangement or agreement, whether oral or written, to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of an insurable interest and are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in subsection (7)(c) of this section.

(16) “Terminally ill” means having an illness or sickness that can reasonably be expected to result in death within twenty-four (24) months or less.

History.

[I.C., § 41-1951](#), as added by 2009, ch. 69, § 1, p. 192; am. 2013, ch. 266, § 10, p. 652.

STATUTORY NOTES

Cross References.

Idaho credit code, § 28-41-101 et seq.

Amendments.

The 2013 amendment, by ch. 266, updated the first statutory reference in the introductory paragraph in subsection (7) in light of the revision of chapter 38, title 41, Idaho Code; deleted “consumer” preceding “credit code” in paragraph (7)(c)(iv); and substituted “rule 144A, [17 CFR 230.144A](#), promulgated under” for “rule 144 of” in paragraph (14)(b).

Federal References.

The federal securities act of 1933, referred to in paragraph (14)(b), is codified as [15 USCS § 77a et seq.](#)

§ 41-1952. License requirement. — (1) A person shall not act as a life settlement provider or life settlement broker where the owner of the life insurance policy is a resident of this state without first obtaining a license from the director as a life insurance producer under chapter 10, title 41, Idaho Code, and complying with the additional requirements set forth in [sections 41-1950 through 41-1965, Idaho Code](#).

(2) Not later than ten (10) days from the first day of operating as a life settlement broker or provider, and thereafter upon renewal of the life insurance producer license, the life insurance producer shall notify the director that he or she is acting as a life settlement broker or provider on a form prescribed by the director, and shall pay any applicable fee to be determined by the director specified by rule pursuant to [section 41-401, Idaho Code](#). Notification shall include an acknowledgment by the life insurance producer that he or she will operate as a life settlement broker in accordance with [sections 41-1950 through 41-1965, Idaho Code](#).

(3) The insurer that issued the policy being settled shall not be responsible for any act or omission of a life settlement broker or life settlement provider arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of a life settlement contract from the life settlement provider or life settlement broker in connection with the life settlement contract.

History.

[I.C., § 41-1952](#), as added by 2009, ch. 69, § 1, p. 192.

§ 41-1953. Filing of life settlement contracts and disclosure statements. — A person shall not use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with the director accompanied by a certification that the form is in compliance with [sections 41-1950 through 41-1965, Idaho Code](#). The director may disapprove a life settlement contract form or disclosure statement form if, in the director's opinion, the contract or provisions contained therein fail to meet the requirements of [sections 41-1950 through 41-1965, Idaho Code](#), or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the owner. At the director's discretion, the director may require the submission of advertising material.

History.

[I.C., § 41-1953](#), as added by 2009, ch. 69, § 1, p. 192.

§ 41-1954. Reporting requirements and privacy. — (1) Each life settlement provider shall file with the director, on or before March 1 of each year, an annual statement containing such information on a form prescribed by the director or as prescribed by rule. Such information shall be limited to only those transactions where the owner is a resident of this state.

(2) Except as otherwise allowed or required by law, a life settlement provider, life settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure is: (a) Necessary to effect a life settlement between the owner and a life settlement provider and the owner and insured have provided prior written consent to the disclosure; (b) Provided in response to an investigation or examination by the director or any other governmental officer or agency; (c) A term of or condition to the transfer of a policy by one (1) life settlement provider to another life settlement provider; (d) Necessary to permit a financing entity, related provider trust or special purpose entity to finance the purchase of policies by a life settlement provider and the owner and insured have provided prior written consent to the disclosure; (e) Necessary to allow the life settlement provider or life settlement broker or their authorized representatives to make contacts for the purpose of determining health status; (f) Required to purchase stop loss coverage or financial guaranty insurance; or (g) Permitted by any other provision of applicable law.

History.

I.C., § 41-1954, as added by 2009, ch. 69, § 1, p. 192.

§ 41-1955. Examination and records. — (1) A person required to be licensed by [sections 41-1950 through 41-1965, Idaho Code](#), is subject to examination as authorized in chapter 2, title 41, Idaho Code, and shall for five (5) years retain copies of all:

(a) Proposed, offered and executed contracts, purchase agreements, underwriting documents, policy forms, executed disclosure statements and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later;

(b) All checks, drafts or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date of the transaction; and

(c) All other records and documents related to the requirements of [sections 41-1950 through 41-1965, Idaho Code](#).

(2) The provisions of this section does [do] not relieve a person of the obligation to produce these documents to the director after the retention period has expired if the person has retained the documents.

(3) Records required to be retained by this section must be legible and complete and in accordance with [section 28-50-107, Idaho Code](#), and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

History.

[I.C., § 41-1955](#), as added by 2009, ch. 69, § 1, p. 192.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in subsection (2) was added by the compiler to correct the syntax of the sentence.

§ 41-1956. Disclosure to owner upon application. — With each application for a life settlement contract, a life settlement provider or life settlement broker shall provide the owner with at least the following disclosures no later than the time the application for the life settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the owner and the life settlement provider or life settlement broker, and shall provide the following information:

(1) There are possible alternatives to life settlement contracts including any accelerated death benefits or policy loans offered under the owner's life insurance policy.

(2) That a life settlement broker represents exclusively the owner, and not the insurer or the life settlement provider, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

(3) Some or all of the proceeds of the life settlement may be taxable under federal and state law, and assistance should be sought from a professional tax advisor.

(4) Proceeds of the life settlement could be subject to the claims of creditors.

(5) Receipt of the proceeds of a life settlement may adversely affect the owner's eligibility for medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

(6) The owner has the right to rescind a life settlement contract within twenty (20) days of the date it is executed by all parties. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given, and the owner repays all proceeds and any premiums, loans and loan interest paid on account of the life settlement contract within the rescission period. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded, subject to repayment by

the owner or the owner's estate of all life settlement proceeds and any premiums, loans and loan interest.

(7) Funds will be sent to the owner within three (3) business days after the life settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

(8) Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the owner. Assistance should be sought from a financial adviser.

(9) Disclosure to an owner shall include distribution of a brochure describing the process of life settlements. The national association of insurance commissioners (NAIC) form for the brochure shall be used unless another form is developed or approved by the director.

(10) The disclosure document shall contain the following language: "All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement between the owner and the life settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two (2) years."

(11) Following execution of a life settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in [sections 41-1950 through 41-1965, Idaho Code](#). This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less. All such contacts shall be made only by a life settlement provider licensed in the state in which the owner resided at the time of the life settlement, or by the authorized representative of a duly licensed life settlement provider.

History.

I.C., § 41-1956, as added by 2009, ch. 69, § 1, p. 192.

STATUTORY NOTES**Compiler's Notes.**

For further information on life settlements and the national association of insurance commissioners, referred to in subsection (9), see *<http://www.insureuonline.org/consumerlifeviaticals.htm>*.

§ 41-1957. Disclosure to owner by provider upon settlement contract.

— A life settlement provider shall provide the owner with at least the following disclosures prior to the time the owner signs the life settlement contract. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and shall provide the following information:

(1) The affiliation, if any, between the life settlement provider and the issuer of the insurance policy to be settled;

(2) The name, business address and telephone number of the life settlement provider;

(3) If an insurance policy to be settled has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be settled, the possible loss of coverage on the other lives under the policy and shall be advised to consult with his or her insurance producer or the insurer issuing the policy for advice on the proposed life settlement;

(4) The dollar amount of the current death benefit payable under the policy or certificate. If known, the life settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the extent to which the owner's interest in those benefits will be transferred as a result of the life settlement contract; and

(5) The name, business address and telephone number of the independent third party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

History.

I.C., § 41-1957, as added by 2009, ch. 69, § 1, p. 192.

§ 41-1958. Disclosure to owner by broker upon settlement contract.

— A life settlement broker shall provide the owner with at least the following disclosures prior to the time the owner signs the life settlement contract. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

(1) The name, business address and telephone number of the life settlement broker;

(2) A full, complete and accurate description of all offers, counteroffers, acceptances and rejections relating to the proposed life settlement contract;

(3) A written disclosure of any affiliations or contractual arrangements between the life settlement broker and any person making an offer in connection with the proposed life settlement contracts;

(4) The amount and method of calculating the broker's compensation, which term "compensation" includes anything of value to be paid or given to a life settlement broker for the placement of a policy; and

(5) Where any portion of the life settlement broker's compensation is taken from a proposed life settlement offer, the total amount of the life settlement offer and the percentage of the life settlement offer comprised by the life settlement broker's compensation.

History.

I.C., § 41-1958, as added by 2009, ch. 69, § 1, p. 192.

§ 41-1959. Notice of change by provider. — If the life settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within twenty (20) days after the change.

History.

I.C., § 41-1959, as added by 2009, ch. 69, § 1, p. 192.

§ 41-1960. General rules. — (1) A life settlement provider entering into a life settlement contract shall first obtain:

(a) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a life settlement contract; and

(b) A document in which the insured consents to the release of his or her medical records to a licensed life settlement provider, life settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

(2) Within twenty (20) days after an owner executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to settle the policy, the life settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a settled policy. The notice shall be accompanied by the documents required by subsection (3) of this section.

(3) The life settlement provider shall deliver:

(a) A copy of the medical release required under subsection (1)(b) of this section;

(b) A copy of the owner's application for the life settlement contract;

(c) The notice required under subsection (2) of this section; and

(d) A request for verification of coverage to the insurer that issued the life policy that is the subject of the life transaction. The NAIC's form for verification of coverage shall be used unless another form is developed and approved by the director.

(4) The insurer shall respond to a request for verification of coverage submitted on an approved form by a life settlement provider or life settlement broker within thirty (30) calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at that

time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on an NAIC form or any other form approved by the director. The insurer shall accept an original or facsimile or electronic copy of such request and any accompanying authorization signed by the owner. Failure by the insurer to meet its obligations under this subsection shall be a violation of [section 41-1964, Idaho Code](#).

(5) Prior to or at the time of execution of the life settlement contract, the life settlement provider shall obtain a witnessed document in which the owner consents to the life settlement contract, represents that the owner has a full and complete understanding of the life settlement contract, that he or she has a full and complete understanding of the benefits of the life insurance policy, acknowledges that he or she is entering into the life settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(6) If a life settlement broker performs these activities required of the life settlement provider, the provider is deemed to have fulfilled the requirements of this section.

(7) All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state and federal law relating to confidentiality of medical information.

(8) All life settlement contracts entered into in this state, or covering a resident of this state as owner, shall provide the owner with an absolute right to rescind the contract within twenty (20) calendar days of the date upon which the life settlement contract is executed by all parties. Rescission by the owner is conditioned upon the owner both giving notice and repaying to the life settlement provider within the rescission period all proceeds of the settlement and any premiums, loans and loan interest paid by or on behalf of the life settlement provider in connection with or as a consequence of the life settlement. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded, subject to repayment to the life settlement provider or other person of all life settlement proceeds, and any premiums, loans and loan interest that

have been paid by the life settlement provider or other person. In the event of any rescission, if the life settlement provider has paid commissions or other compensation to a life settlement broker in connection with the rescinded transaction, the life settlement broker shall refund all such commissions and compensation to the life settlement provider within five (5) business days following receipt of written demand from the life settlement provider, which demand shall be accompanied by either the owner's notice of rescission if rescinded at the election of the owner, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

(9) The life settlement provider shall instruct the owner to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to an independent escrow agent. Within three (3) business days after the date the escrow agent receives the documents, or from the date the life settlement provider receives the documents, if the owner erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the life settlement into an escrow or trust account maintained in a state or federally-chartered financial institution whose deposits are insured by the federal deposit insurance corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the life settlement provider or related provider trust or other designated representative of the life settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the owner.

(10) Failure to tender consideration to the owner for the life settlement contract within the time set forth in the disclosure pursuant to [section 41-1956\(7\), Idaho Code](#), renders the life settlement contract voidable by the owner for lack of consideration until the time consideration is tendered to and accepted by the owner.

(11) Contacts with the insured for the purpose of determining the health status of the insured by the life settlement provider or life settlement broker after the life settlement has occurred shall only be made by the life settlement provider or broker licensed in this state or its authorized

representatives and shall be limited to once every three (3) months for insureds with a life expectancy of more than one (1) year, and to no more than once per month for insureds with a life expectancy of one (1) year or less. The provider or broker shall explain the procedure for these contacts at the time the life settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Life settlement providers and life settlement brokers shall be responsible for the actions of their authorized representatives.

History.

I.C., § 41-1960, as added by 2009, ch. 69, § 1, p. 192.

STATUTORY NOTES

Compiler's Notes.

For further information on life settlements and the national association of insurance commissioners, referred to in subsection (9), see <http://www.insureuonline.org/consumerlifeviaticals.htm>.

§ 41-1961. Permitted life settlements and supporting documentation.

— (1) It is a violation of the provisions of [sections 41-1950 through 41-1965, Idaho Code](#), for any person to enter into a life settlement contract at any time prior to the issuance of a policy which is the subject of a life settlement contract or within a two (2) year period commencing with the date of issuance of the insurance policy or certificate unless the owner certifies to the life settlement provider that one (1) or more of the following conditions have been met within the two (2) year period:

(a) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four (24) months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(b) As part of the certification, the owner submits independent evidence to the life settlement provider that one (1) or more of the following conditions have been met within the two (2) year period:

(i) The owner or insured is terminally or chronically ill;

(ii) The owner's spouse dies;

(iii) The owner divorces his or her spouse;

(iv) The owner retires from full-time employment;

(v) The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or

(vi) A final order, judgment or decree is entered by a court of competent jurisdiction on the application of a creditor or the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee or liquidator to all or a substantial part of the owner's assets.

(2) Copies of the independent evidence described in subsection (1)(b) of this section and documents required in [section 41-1960\(1\) through \(5\), Idaho Code](#), shall be submitted to the insurer when the life settlement provider or other party entering into a life settlement contract with an owner submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the life settlement provider that the copies are true and correct copies of the documents received by the life settlement provider.

(3) If the life settlement provider submits to the insurer a copy of the owner or insured's certification described in and the independent evidence required by subsection (1)(b) of this section when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the life settlement provider, the copy shall be deemed to conclusively establish that the life settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

(4) No insurer may, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, life settlement provider or life settlement broker sign any forms, disclosures, consent or waiver form that has not been filed with the director for use in connection with life settlement contracts in this state.

(5) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within thirty (30) days with written acknowledgment confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary and shall not otherwise seek to interfere with any life settlement contract lawfully entered into in this state.

History.

[I.C., § 41-1961](#), as added by 2009, ch. 69, § 1, p. 192.

§ 41-1962. Prohibited practices and conflicts of interest. — (1) It is a violation of the provisions of sections 41-1950 through 41-1965, Idaho Code, for any person to engage in any act that constitutes or promotes a STOLI regarding any resident of this state.

(2) With respect to any life settlement contract or insurance policy, no life settlement broker knowingly shall solicit an offer from, effectuate a life settlement with or make a sale to any life settlement provider, life settlement purchaser, financing entity or related provider trust that is an affiliate of such life settlement broker unless such relationship is first disclosed to the owner.

(3) With respect to any life settlement contract or insurance policy, no life settlement provider knowingly shall enter into a life settlement contract with an owner, if, in connection with such life settlement contract, anything of value will be paid to a life settlement broker that is an affiliate of such life settlement provider or any investor, financing entity or related provider trust that is involved in such life settlement contract unless such relationship is first disclosed to the owner.

(4) No person shall enter into a premium finance agreement with any other person or affiliate thereof pursuant to which such person shall receive any proceeds, fees or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any life settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of such agreement; provided further that any payments, charges, fees or other amounts in addition to the amounts required to pay the principal, interest and service charges related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or to his or her estate if he or she is not living at the time of the determination of overpayment.

(5) In the solicitation, application or issuance of a life insurance policy, no person shall employ any device, scheme or artifice that would result in a

violation of [section 41-1804, Idaho Code](#).

(6) No life settlement provider shall enter into a life settlement contract unless the life settlement promotional, advertising and marketing materials, as may be prescribed by rule, have been filed with the director. In no event shall any marketing materials expressly reference that the insurance is “free” for any period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of the provisions of [sections 41-1950 through 41-1965, Idaho Code](#).

(7) No life insurance producer, insurance company, life settlement broker or life settlement provider shall make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

History.

[I.C., § 41-1962](#), as added by 2009, ch. 69, § 1, p. 192.

STATUTORY NOTES

Cross References.

STOLI, § 41-1951.

§ 41-1963. Advertising for life settlements. — No person required to be licensed pursuant to [sections 41-1950 through 41-1965, Idaho Code](#), shall engage in any false or misleading advertising, solicitation, or practice. In no case shall a life settlement broker or provider directly or indirectly market, advertise, solicit or otherwise promote the purchase of a new policy with the primary emphasis on settling the policy or use the words “free,” “no cost” or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy.

History.

[I.C., § 41-1963](#), as added by 2009, ch. 69, § 1, p. 192.

§ 41-1964. Penalty — Unfair trade practices. — A violation of the provisions of sections 41-1950 through 41-1965, Idaho Code, shall be considered an unfair trade practice under chapter 13, title 41, Idaho Code, subject to the penalties contained in that chapter.

History.

I.C., § 41-1964, as added by 2009, ch. 69, § 1, p. 192.

§ 41-1965. Authority to promulgate rules. — The director shall have the authority to promulgate rules implementing the provisions of **sections 41-1950 through 41-1964, Idaho Code.**

History.

I.C., § 41-1965, as added by 2009, ch. 69, § 1, p. 192.

STATUTORY NOTES

Compiler's Notes.

Section 2 of S.L. 2009, ch. 69 provided: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

Chapter 20

GROUP LIFE INSURANCE

Sec.

- 41-2001. Scope of chapter — Short title.
- 41-2002. Group contracts must meet group requirements.
- 41-2003. Employee groups.
- 41-2004. Labor union groups.
- 41-2005. Debtor groups.
- 41-2006. Public employee groups.
- 41-2007. Trustee groups.
- 41-2008. Credit union groups.
- 41-2009. Dependents' coverage.
- 41-2010. Provisions required in group contracts.
- 41-2011. Grace period.
- 41-2012. Incontestability.
- 41-2013. Application — Statements deemed representations.
- 41-2014. Insurability.
- 41-2015. Misstatement of age.
- 41-2016. Payment of benefits.
- 41-2017. Certificate.
- 41-2018. Conversion on termination of eligibility.
- 41-2019. Conversion on termination of policy.
- 41-2020. Death pending conversion.
- 41-2021. Notice as to conversion right.
- 41-2022. Readjustment of premium.

41-2023. Application of dividends — Rate reductions.

41-2024. “Employee life insurance” defined.

41-2025. Assignment of incidents of ownership in group life insurance policies, including conversion privileges.

41-2026. Policy standards — Replacement contracts.

§ 41-2001. Scope of chapter — Short title. — (1) This chapter applies only to group life insurance.

(2) This chapter may be known and cited as the “group life insurance law”.

History.

1961, ch. 330, § 466, p. 645.

CASE NOTES

Cited Maxwell v. Cumberland Life Ins. Co., 113 Idaho 808, 748 P.2d 392 (1987).

§ 41-2002. Group contracts must meet group requirements. — (1) Unless as otherwise provided in subsection (3) of this section, no life insurance policy shall be delivered or issued for delivery in this state insuring the lives of more than one (1) individual unless to one (1) of the groups as provided for in sections 41-2003 through 41-2007 of this chapter, and unless in compliance with the other applicable provisions of this chapter.

(2) Subsection (1) above, shall not apply to life insurance policies:

(a) Insuring only individuals related by blood, marriage or legal adoption;
or

(b) Insuring only individuals having a common interest through ownership of a business enterprise, or a substantial legal interest or equity therein, and who are actively engaged in the management thereof;
or

(c) Insuring only individuals otherwise having an insurable interest in each other's lives.

(3) Group life insurance offered to a resident of this state under a group life insurance policy issued to a group other than one described in subsection (1) of this section shall be subject to the following requirements:

(a) No such group life insurance policy shall be delivered in this state unless the director finds that:

(i) The issuance of such group life insurance policy is not contrary to the best interest of the public;

(ii) The issuance of such group life insurance policy would result in economies of acquisition or administration; and

(iii) The benefits of such group life insurance policy are reasonable in relation to the premiums charged.

(b) No such group life insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state, having requirements substantially similar to those

contained in subsection (3)(a)(i), (ii) and (iii), has made a determination that such requirements have been met.

(c) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

(d) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History.

1961, ch. 330, § 467, p. 645; am. 2009, ch. 151, § 1, p. 440.

STATUTORY NOTES

Amendments.

The 2009 amendment, by ch. 151, in subsection (1), added “Unless as otherwise provided in subsection (3) of this section”; and added subsection (3).

CASE NOTES

Cited *Wells v. United States Life Ins. Co.*, 119 Idaho 160, 804 P.2d 333 (Ct. App. 1991).

§ 41-2003. Employee groups. — The lives of a group of individuals may be insured under a policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term “employees” shall include the employees of one (1) or more subsidiary corporations, and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise. The policy may provide that the term “employees” shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term “employees” shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation, by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. A policy issued to insure the employees of a public body may provide that the term “employees” shall include elected or appointed officials.

(2) The premium for the policy shall be paid from the employer’s funds or funds contributed by him, from funds contributed by the insured employees, or from both. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or who have rejected the coverage in writing.

History.

1961, ch. 330, § 468, p. 645; am. 1971, ch. 122, § 9, p. 408; am. 2004, ch. 256, § 1, p. 727.

STATUTORY NOTES**Effective Dates.**

Section 5 of S.L. 2004, ch. 256 declared an emergency. Approved March 23, 2004.

§ 41-2004. Labor union groups. — The lives of a group of individuals may be insured under a policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.

(2) The premium for the policy shall be paid by the policyholder, from the union's funds, from funds contributed by the insured members specifically for their insurance, or from both. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or who have rejected the coverage in writing.

History.

1961, ch. 330, § 469, p. 645; am. 2004, ch. 256, § 2, p. 727.

STATUTORY NOTES

Effective Dates.

Section 5 of S.L. 2004, ch. 256 declared an emergency. Approved March 23, 2004.

§ 41-2005. Debtor groups. — The lives of a group of individuals may be insured under a policy issued to a creditor, or to a trustee or trustees or agent designated by two (2) or more creditors, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term “debtors” shall include the debtors of one (1) or more subsidiary corporations, and the debtors of one (1) or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract, or otherwise.

(2) The premium for the policy shall be paid by the policyholder, either from the creditor’s funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent (75%) of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred (100) persons yearly, or may reasonably be expected to receive at least one hundred (100) new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured. The

policy may exclude from the classes eligible for insurance classes of debtors determined by age.

(4) The amount of insurance on the life of a debtor shall at no time exceed the amount owed by him to the creditor, or one hundred fifty thousand dollars (\$150,000), whichever is less.

(5) The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

History.

1961, ch. 330, § 470, p. 645; am. 1967, ch. 395, § 1, p. 1166; am. 1974, ch. 152, § 2, p. 1375; am. 1983, ch. 119, § 4, p. 264; am. 2005, ch. 67, § 1, p. 232.

CASE NOTES

Estoppel.

Where there was no evidence to suggest that the decedent had any knowledge that the statutory limitation had been exceeded, nor did there appear any reason why he should not reasonably and justifiably have relied upon the superior knowledge and expertise of the insurer for full compliance with the law, the insurer would be estopped from asserting the illegality of its bargained for policies. *Williams v. Continental Life & Accident Co.*, 100 Idaho 71, 593 P.2d 708 (1979).

Cited *Martinez v. Idaho Counties Reciprocal Mgt. Program*, 134 Idaho 247, 999 P.2d 902 (2000).

§ 41-2006. Public employee groups. — The lives of a group of individuals may be insured under a policy issued to the departmental head or to an association of public employees formed for purposes other than obtaining insurance and having, when the policy is placed in force, a membership in the classes eligible for insurance of not less than seventy-five per cent (75%) of the number of employees eligible for membership in such classes, which association or departmental head shall be deemed the policyholder, to insure members of such association or public employees for the benefit of persons other than the departmental head, the association or any of its officials, subject to the following requirements:

(1) The persons eligible for insurance under the policy shall be all of the members of the association or employees of the department, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the association, or both.

(2) The premium for the policy shall be paid by the policyholder, either from the association's own funds, or from charges collected from the insured members or employees specifically for the insurance, or from both. Any charges collected from the insured members or employees specifically for the insurance, and the dues of the association if they include the cost of insurance, shall be collected through deductions by the employer from salaries of the members or employees. Such deductions from salary may be paid by the employer to the association or directly to the insurer. No policy may be placed in force unless and until at least seventy-five per cent (75%) of the then eligible members of the association or employees of the department, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have authorized their employer to make the required deductions from salary.

(3) Charges collected from the insured members or employees specifically for the insurance, and the dues of the association if they include the cost of insurance, shall be determined according to each attained age or in not less than four (4) reasonably spaced attained age groups. In no event shall the rate of such dues or charges be level for all members or employees regardless of attained age.

(4) The policy must cover at least five (5) persons at the date of issue.

(5) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members, employees, or by the association. Such amounts shall in no event exceed three thousand dollars (\$3,000) in the case of any member or employee, and shall not exceed five hundred dollars (\$500) in the case of retired members or employees and members or employees over age sixty-five (65).

(6) As used herein “employees” means employees of the United States government, or of any state, or any political subdivision or instrumentality of any of them.

(7) Groups heretofore or hereafter written under [section 59-1201 \[67-5763\]](#), [Idaho Code](#), are not subject to this section.

History.

1961, ch. 330, § 471, p. 645; am. 1969, ch. 214, § 55, p. 625; am. 1971, ch. 122, § 10, p. 408.

STATUTORY NOTES

Compiler’s Notes.

Section 59-1201, referred to in subsection (7), was redesignated as § 67-5763 by S.L. 1980, ch. 106, § 12.

§ 41-2007. Trustee groups. — The lives of a group of individuals may be insured under a policy issued to the trustees of a fund established in this state by two (2) or more employers in the same industry or to the trustees of a fund established by one (1) or more labor unions, or by one (1) or more employers and one (1) or more labor unions, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both. The policy may provide that the term “employees” shall include retired employees, and the individual proprietor or partners if an employer is an individual proprietor or a partnership. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term “employees” shall include the trustees, or their employees, or both, if their duties are principally connected with such trusteeship.

(2) The premium for the policy shall be paid by the trustees from funds contributed by the employer or employers of the insured persons, or by the union or unions, or from funds contributed by the insured persons, or from any combination of these. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or who have rejected the coverage in writing.

(3) The policy shall not require that, if a participating employer discontinues membership in the association, the insurance of his employees

shall cease solely by reason of such discontinuance.

History.

1961, ch. 330, § 472, p. 645; am. 1971, ch. 122, § 11, p. 408; am. 1974, ch. 196, § 1, p. 1504; am. 2004, ch. 256, § 3, p. 727.

STATUTORY NOTES

Effective Dates.

Section 5 of S.L. 2004, ch. 256 declared an emergency. Approved March 23, 2004.

CASE NOTES

Decisions Under Prior Law Failure to Obtain Sufficient Members.

Where an insurance company proposed to issue a group policy covering members of a movers' and warehousemen's conference, but declined to issue the master policy because of the failure of the group to obtain applications of at least one hundred members and an average of at least five per employer unit, as required by former law, the company was not estopped to deny coverage in refusing to pay the claim of the widow of a group member who had paid the proposed premium to a purported agent. *Whitney v. Continental Life & Acc. Co.*, 89 Idaho 96, 403 P.2d 573 (1965).

§ 41-2008. Credit union groups. — The lives of a group of individuals may be insured under a policy issued to a credit union, which shall be deemed the policyholder, to insure eligible members of the credit union for the benefit of persons other than the credit union or its officials, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the credit union, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer, or all of any class or classes thereof determined by conditions pertaining to their age or membership in the credit union or both.

(2) The premium for the policy shall be paid by the policyholder, either wholly from the credit union's funds, or partly from such funds and partly from funds contributed by the insured members, specifically for their insurance. No policy shall be issued for which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance.

(3) The policy must cover at least twenty-five (25) members at the date of issue.

(4) The amount of insurance under the policy shall not exceed the amount of the total shares and deposits of the member in or with the credit union.

History.

I.C., § 41-2008, as added by 1969, ch. 214, § 56, p. 625.

STATUTORY NOTES

Prior Laws.

Former § 41-2008, which comprised S.L. 1961, ch. 330, § 473, p. 645, was repealed by S.L. 1963, ch. 361, § 1.

§ 41-2009. Dependents' coverage. — Any group life policy issued under section 41-2003[, Idaho Code] (employee groups), or 41-2004[, Idaho Code] (labor union groups), or 41-2006[, Idaho Code] (public employee groups), or 41-2007[, Idaho Code] (trustee groups) may be extended to insure the employees or members against loss due to the death of their spouses and minor children, or any class or classes thereof, subject to the following requirements:

(1) The premium for the insurance shall be paid by the policyholder, either from the employer's or union's funds or funds contributed by the employer or union, or from funds contributed by the insured employees or members, or from both. If no part of the premium is to be derived from funds contributed by the employees or members, all eligible employees or members, excluding any as to whose family members evidence of insurability is not satisfactory to the insurer, must be insured with respect to their spouses and children.

(2) Upon termination of the insurance with respect to the members of the family of any employee or member by reason of the employee's or member's termination of employment, termination of membership in the class or classes eligible for coverage under the policy, or death, the spouse shall be entitled to have issued by the insurer, without evidence of insurability, an individual policy of life insurance, without disability or other supplementary benefits, providing application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after such termination, subject to the requirements of subsections (1), (2) and (3) of [section 41-2018, Idaho Code](#). If any group policy terminates or is amended so as to terminate the insurance of any class of employees or members and the employee or member is entitled to have issued an individual policy, under [section 41-2019, Idaho Code](#), the spouse shall also be entitled to have issued by the insurer an individual policy, subject to the conditions and limitations provided above. If the spouse dies within the period during which he would have been entitled to have an individual policy issued in accordance with this provision, the amount of life insurance which he would have been entitled to have issued under such individual policy shall be payable as a claim under the group

policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

(3) Notwithstanding [section 41-2017, Idaho Code](#), only one (1) certificate need be issued for delivery to an insured person if a statement concerning any dependent's coverage is included in such certificate.

History.

1961, ch. 330, § 474, p. 645; am. 1969, ch. 214, § 57, p. 625; 1976, ch. 114, § 1, p. 449; am. 2004, ch. 256, § 4, p. 727.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in the introductory paragraph were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 5 of S.L. 2004, ch. 256 declared an emergency. Approved March 23, 2004.

§ 41-2010. Provisions required in group contracts. — No policy of group life insurance shall be delivered in this state unless it contains in substance the provisions set forth in sections 41-2011 through 41-2020[, Idaho Code] of this chapter or provisions which in the opinion of the director are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder; except, however, that:

(1) Sections 41-2016 to 41-2020[, Idaho Code,] inclusive shall not apply to policies issued to a creditor to insure debtors of such creditor;

(2) The standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and

(3) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the director is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

History.

1961, ch. 330, § 475, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in the introductory paragraph and in subsection (1) were added by the compiler to conform to the statutory citation style.

§ 41-2011. Grace period. — The group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

History.

1961, ch. 330, § 476, p. 645.

RESEARCH REFERENCES

ALR. — Effective date of group life insurance, as to individual policies of employees. [66 A.L.R.3d 1175](#).

§ 41-2012. Incontestability. — The group life insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premium, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him.

History.

1961, ch. 330, § 477, p. 645.

CASE NOTES

In general.

Misstatement of age.

Policy never in force.

Purpose.

Second policy.

In General.

Incontestability clauses preclude any defense after the stipulated period on account of false statements in the application for the policy. *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

Misstatement of Age.

Where the two-year period had run, all defenses premised on false statements in the insured's application for group credit life insurance were precluded, including a false statement as to insured's age. *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

Policy Never in Force.

Where insured predeceased the effective date of the insurance upon his life, the policy was never “in force” within the meaning of this section, consequently, the insurer’s covenant not to contest the policy was inapplicable, and summary judgment was appropriate. *Wells v. United States Life Ins. Co.*, 119 Idaho 160, 804 P.2d 333 (Ct. App. 1991).

Purpose.

The principal function of an incontestability clause is to cut off defenses, such as misrepresentations, that go to the validity of the policy after the policy has been in force and effect for a period of time. *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

The purpose of an incontestability clause is to require the insurer to investigate and act with reasonable promptness if it wishes to deny liability on the ground of false representation or warranty by the insured. It prevents the insurer from lulling the insured into a sense of security only to litigate the issue later, possibly after the death of the insured. *Maxwell v. Cumberland Life Ins. Co.*, 113 Idaho 808, 748 P.2d 392 (1987).

Second Policy.

Where the insured died less than a year after a policy, which by its terms was incontestable after two years, was issued, but such policy was an amendment of an earlier policy covering the insured and issued to effect broader coverage, but the earlier policy was not in evidence, there was an issue of fact as to whether the second policy was an extension of the first and whether the first policy contained an incontestability clause which would preclude the insurer from contesting the second policy. *Matthews v. New York Life Ins. Co.*, 92 Idaho 372, 443 P.2d 456 (1968).

§ 41-2013. Application — Statements deemed representations. — The group life insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued and become a part of the contract; that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his beneficiary.

History.

1961, ch. 330, § 478, p. 645.

§ 41-2014. Insurability. — The group life insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage.

History.

1961, ch. 330, § 479, p. 645.

§ 41-2015. Misstatement of age. — The group life insurance policy shall contain a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used.

History.

1961, ch. 330, § 480, p. 645.

CASE NOTES

Cited Maxwell v. Cumberland Life Ins. Co., 113 Idaho 808, 748 P.2d 392 (1987).

§ 41-2016. Payment of benefits. — The group life insurance policy shall contain a provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, subject to the provisions of the policy in the event there is no designated beneficiary as to all or any part of such sum living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding five hundred dollars (\$500) to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

History.

1961, ch. 330, § 481, p. 645.

§ 41-2017. Certificate. — The group life insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in sections 41-2018, 41-2019 and 41-2020[, Idaho Code,] following.

History.

1961, ch. 330, § 482, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of the section was added by the compiler to conform to the statutory citation style.

§ 41-2018. Conversion on termination of eligibility. — There shall be a provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after such termination, and provided further that:

(1) The individual policy shall, at the option of such person, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for;

(2) The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination less the amount of any life insurance for which such person is or becomes eligible under the same or any other group policy within thirty-one (31) days after such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

(3) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his age attained on the effective date of the individual policy.

History.

1961, ch. 330, § 483, p. 645.

RESEARCH REFERENCES

ALR. — Termination of coverage under group policy with regard to termination of employment. [32 A.L.R.4th 1037](#).

§ 41-2019. Conversion on termination of policy. — The group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five (5) years prior to such termination date shall be entitled to have issued to him by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by section 41-2018[, Idaho Code], except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

(1) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one (31) days after such termination, and (2) Two thousand dollars (\$2,000).

History.

1961, ch. 330, § 484, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of the introductory paragraph was added by the compiler to conform to the statutory citation style.

§ 41-2020. Death pending conversion. — The group life insurance policy shall contain a provision that if a person insured under the policy dies during the period within which he would have been entitled to have an individual policy issued to him in accordance with sections 41-2018 and 41-2019[, Idaho Code,] and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

History.

1961, ch. 330, § 485, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the middle of the section was added by the compiler to conform to the statutory citation style.

§ 41-2021. Notice as to conversion right. — If any individual insured under a group life insurance policy hereafter delivered in this state becomes entitled under the terms of such policy to have an individual policy of life insurance issued to him without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least fifteen (15) days prior to the expiration date of such period, then, in such event the individual shall have an additional period within which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire fifteen (15) days next after the individual is given such notice but in no event shall such additional period extend beyond sixty (60) days next after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this section.

History.

1961, ch. 330, § 486, p. 645.

§ 41-2022. Readjustment of premium. — Any group life insurance contract may provide for a readjustment of the premium rate based upon the experience thereunder.

History.

1961, ch. 330, § 487, p. 645.

§ 41-2023. Application of dividends — Rate reductions. — If a policy dividend is hereafter declared or a reduction in rate is hereafter made or continued for the first or any subsequent year of insurance under any policy of group life insurance heretofore or hereafter issued to any policyholder, the excess, if any, of the aggregate dividends or rate reductions under such policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under such policies made from funds contributed by the policyholder, or by an employer of insured persons, or by a union or association to which the insured persons belong, including expenditures made in connection with administration of such policies, shall be applied by the policyholder for the sole benefit of insured employees or members.

History.

1961, ch. 330, § 488, p. 645.

§ 41-2024. “Employee life insurance” defined. — (1) “Employee life insurance” is that plan of life insurance, other than salary savings life insurance or pension trust insurance and annuities, under which individual policies are issued to the employees of any employer and the employer, or to the members of a professional association or its employees and where such policies are issued on the lives of not less than four (4) persons at date of issue. Premiums for such policies shall be paid either wholly from the employer’s or member’s funds, or funds contributed by him, or partly from such funds and partly from funds contributed by the insured employees.

(2) Any group which is eligible for “group disability insurance” under [section 41-2202, Idaho Code](#), will be eligible for employee life insurance under [section 41-2024, Idaho Code](#).

History.

1961, ch. 330, § 489, p. 645; am. 1974, ch. 85, § 1, p. 1176; am. 1975, ch. 207, § 3, p. 575.

§ 41-2025. Assignment of incidents of ownership in group life insurance policies, including conversion privileges. — Nothing in this insurance code or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of his incidents of ownership under such policy, including but not limited to the privilege to have issued to him an individual policy of life insurance pursuant and subject to the provisions of sections 41-2018, 41-2019 and 41-2021, Idaho Code, and the right to name a beneficiary. Subject to the terms of the policy or agreement between the insured, the group policyholder and the insurer relating to assignment of incidents of ownership thereunder, such an assignment by an insured, made either before or after the effective date of this act, is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is to be effective, all of such incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with sections 41-2018 and 41-2019, Idaho Code, prior to receipt of notice of the assignment.

History.

I.C., § 41-2025, as added by 1970, ch. 50, § 1, p. 102.

STATUTORY NOTES

Compiler's Notes.

The phrase “the effective date of this act” near the middle of this section refers to the effective date of S.L. 1970, Chapter 50, which was effective February 25, 1970.

Effective Dates.

Section 3 of S.L. 1970, ch. 50 declared an emergency. Approved February 25, 1970.

§ 41-2026. Policy standards — Replacement contracts. — (1) Any insurer providing replacement coverage with respect to group life insurance benefits within a period of sixty (60) days from the date of discontinuance of the prior policy providing such benefits shall immediately cover all members of the group and dependents validly covered under the previous policy at the date of discontinuance who are within the definitions of eligibility and who would otherwise be eligible for coverage under the succeeding insurer's policy, regardless of any limitations or exclusions relating to active employment or nonconfinement.

(2) Any member of the group or dependent entitled to coverage under a succeeding insurer's policy pursuant to subsection (1) of this section shall continue to be covered by the succeeding insurer until the date coverage would terminate for a member of the group or dependent in accordance with the provisions of the succeeding insurer's policy.

(3) No provision in the succeeding insurer's policy of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding insurer's policy shall be applied with respect to those members of the group and dependents validly insured under the prior insurer's policy on the date of discontinuance, if benefits would have been payable under the prior insurer's policy.

(4) In a situation where a determination of the prior insurer's benefit is required by the succeeding insurer, at the succeeding insurer's request, the prior insurer shall furnish a statement of benefits available or pertinent information, sufficient to permit verification of the benefit determination by the succeeding insurer.

History.

I.C., § 41-2026, as added by 1981, ch. 67, § 1, p. 97.

Chapter 21

DISABILITY INSURANCE POLICIES

Sec.

41-2101. Scope of chapter.

41-2102. Short title.

41-2103. Scope and format of policy.

41-2104. Required provisions — Captions — Omissions — Substitutions.

41-2105. Entire contract — Changes.

41-2106. Time limit on certain defenses.

41-2107. Grace period.

41-2108. Reinstatement.

41-2109. Notice of claim.

41-2110. Claim forms.

41-2111. Proofs of loss.

41-2112. Time of payment of claims.

41-2113. Payment of claims.

41-2114. Physical examination — Autopsy.

41-2115. Legal actions.

41-2116. Change of beneficiary.

41-2117. Optional policy provisions.

41-2118. Change of occupation.

41-2119. Misstatement of age.

41-2120 — 41-2122. Other insurance in this insurer — Insurance with other insurers — Provision of service or expense incurred basis — Other benefits. [Repealed.]

41-2123. Relation of earnings to insurance.

41-2124. Unpaid premiums.

41-2125. Conformity with state statutes.

41-2126. Illegal occupation.

41-2127. Intoxicants and narcotics.

41-2128. Renewability.

41-2129. Order of certain provisions.

41-2130. Third party ownership.

41-2131. Requirements of other jurisdictions.

41-2132. Policies issued for delivery in another state.

41-2133. Conforming to statute.

41-2134. Age limit.

41-2135. Prohibited policy plans — Provisions.

41-2136. Filing of rates.

41-2137. Franchise Disability Insurance Law.

41-2138. Health insurance — Ten-day free examination.

41-2139. Required provisions — Coverage of dependent child.

41-2140. Required provisions.

41-2141. Coordination of benefits — Coordination with social security benefits.

41-2142. Limitation of benefits for elective abortions.

41-2143. Services provided by governmental entities.

41-2144. Mammography coverage.

41-2145. Health insurance coverage for dependent children. [Repealed.]

41-2146. Coverage provided to persons having insurance.

§ 41-2101. Scope of chapter. — Nothing in this chapter shall apply to or affect:

(1) Any policy of liability or workmen's [worker's] compensation insurance with or without supplementary expense coverage therein.

(2) Any group or blanket policy.

(3) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to disability insurance as: (a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means, or as (b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

(4) Reinsurance.

History.

1961, ch. 330, § 490, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in subsection (1) was added by the compiler to reflect the current provisions of Title 72, Idaho Code.

§ 41-2102. Short title. — This chapter may be cited as the “uniform disability policy provision law.”

History.

1961, ch. 330, § 491, p. 645.

STATUTORY NOTES

Cross References.

Individual accident and health insurance policies, § 41-4201 et seq.

§ 41-2103. Scope and format of policy. — No policy of disability insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

(1) The entire money and other considerations therefor shall be expressed therein;

(2) The time when the insurance takes effect and terminates shall be expressed therein;

(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife and any other dependent or dependents. As used in this subsection (3) and for all new and renewing policies, “dependent” includes an unmarried child under the age of twenty-five (25) years and who receives more than one-half ($\frac{1}{2}$) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

(4) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower case unspaced alphabet length not less than one hundred twenty (120) point (the “text” shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions);

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in [sections 41-2105 through 41-2127, Idaho Code](#), shall be printed, at the insurer’s option, either included with the benefit provisions to which they apply, or under an appropriate caption such as “exceptions,” or “exceptions and reductions,” except that if an exception

or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof;

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the director;

(8) When the policy provides payment for medical or surgical expense to the insured, on a reimbursement basis, or otherwise, the insured shall be entitled to a free choice of medical doctor to perform said services, or the free choice of a podiatrist if the latter is authorized by law to perform the particular medical or surgical services covered under the terms of said policy; and

(9) When the policy provides for payment for the expense of services that are within the lawful scope of practice of a duly licensed optometrist, on a reimbursement basis or otherwise, the insured shall be entitled to a free choice of medical doctor or optometrist to perform such services.

History.

1961, ch. 330, § 492, p. 645; am. 1965, ch. 47, § 1, p. 72; am. 1967, ch. 47, § 1, p. 88; am. 2007, ch. 148, § 1, p. 427; am. 2009, ch. 125, § 1, p. 391.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 148, rewrote subsection (3), which formerly read: “It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policy holder, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age

which shall not exceed nineteen (19) years and any other person dependent upon the policy holder.”

The 2009 amendment, by ch. 125, in subsection (3), substituted the language beginning “As used in this subsection (3)” and ending “or an unmarried child” for “As used in this subsection (3), ‘dependent’ includes an unmarried child under the age of twenty-one (21) years, an unmarried child who is a full time student under the age of twenty-five (25) years and who is financially dependent upon the parent, and an unmarried child”; and in subsection (5), substituted “[sections 41-2105 through 41-2127, Idaho Code](#)” for “sections 41-2105 to 41-2127, inclusive, of this chapter.”

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2104. Required provisions — Captions — Omissions — Substitutions. — (1) Except as provided in subsection (2) below, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in sections 41-2105 to 41-2116[, Idaho Code], inclusive, and sections 41-2139 and 41-2140, Idaho Code, of this chapter, in the words in which the same appear; except, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the director which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the option of the insurer, by such appropriate individual or group captions or sub-captions as the director may approve.

(2) If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

History.

1961, ch. 330, § 493, p. 645; am. 1972, ch. 348, § 1, p. 1030; am. 1974, ch. 66, § 1, p. 1146.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the beginning of subsection (1) was added by the compiler to conform to the statutory citation style.

RESEARCH REFERENCES

ALR. — Type or color of printing for insurance policies, statutes relating to size and other characteristics. [36 A.L.R.3d 464](#).

§ 41-2105. Entire contract — Changes. — There shall be a provision as follows:

“Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitute the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.”

History.

1961, ch. 330, § 494, p. 645.

§ 41-2106. Time limit on certain defenses. — (1) There shall be a provision as follows:

“Time Limit on Certain Defenses:

(a) After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two (2) year period.

(b) No claim for loss incurred or disability, as defined in the policy, commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.”

(2) The policy provision of (1)(a) above shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two (2) year period, nor to limit the application of [sections 41-2118 through 41-2122, Idaho Code](#), in the event of misstatement with respect to age or occupation or other insurance.

(3) Notwithstanding the provisions of [section 41-2106\(2\), Idaho Code](#), if an insurer elects to use a simplified application form, with or without a question as to the applicant’s health at the time of application, but without any questions concerning the insured’s health history or medical treatment history, the policy must cover any loss occurring after twelve (12) months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.

(4) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age fifty (50) or, (b) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, may contain in lieu of the

foregoing, the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption, "Incontestable":

"After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to any statements, other than fraudulent statements, contained in the application."

History.

1961, ch. 330, § 495, p. 645; am. 1976, ch. 135, § 1, p. 507.

STATUTORY NOTES

Compiler's Notes.

Sections 41-2120 through 41-2122, part of the spanned reference near the end of subsection (2), were repealed by S.L. 1997, ch. 319, § 4.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2107. Grace period. — There shall be a provision as follows:

“Grace period: A grace period of (insert a number not less than ‘7’ for weekly premium policies, ‘10’ for monthly premium policies and ‘31’ for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.”

A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision: “Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.”

History.

1961, ch. 330, § 496, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2108. Reinstatement. — (1) There shall be a provision as follows:

“Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.”

(2) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (a) Until at least age fifty (50), or (b) In the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue.

History.

1961, ch. 330, § 497, p. 645.

§ 41-2109. Notice of claim. — (1) There shall be a provision as follows:

“Notice of Claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.”

(2) In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may at its option insert the following between the first and second sentences of the above provision: “Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of the claim, give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured’s right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.”

History.

1961, ch. 330, § 498, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2110. Claim forms. — There shall be a provision as follows:

“Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.”

History.

1961, ch. 330, § 499, p. 645.

§ 41-2111. Proofs of loss. — There shall be a provision as follows:

“Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.”

History.

1961, ch. 330, § 500, p. 645.

CASE NOTES

Defense of laches.

Timely filing.

Defense of Laches.

The plain meaning of this section is that proof of claim for a disability may be submitted at any time within the duration of disability covered by the policy, and for 90 days thereafter. However, this section does not displace the defense of laches where an insurance company shows substantial prejudice from “late” submission of proof of claim. *Goodwin v. Nationwide Ins. Co.*, 104 Idaho 74, 656 P.2d 135 (Ct. App. 1982).

Timely Filing.

The insured’s proof of loss, filed 25 months after the accident, was within the proof of loss notice requirements of the policy, since the insured’s disability was continuous, “the period for which claim is made,” i.e., the aggregate period of disability, had not terminated at the time the insured

filed his claim. *Goodwin v. Nationwide Ins. Co.*, 104 Idaho 74, 656 P.2d 135 (Ct. App. 1982).

§ 41-2112. Time of payment of claims. — There shall be a provision as follows:

“Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.”

History.

1961, ch. 330, § 501, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2113. Payment of claims. — (1) There shall be a provision as follows:

“Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured’s death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.”

(2) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer: (a) “If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$ (insert an amount which shall not exceed \$1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.”

(b) “Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer’s option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.”

History.

1961, ch. 330, § 502, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2114. Physical examination — Autopsy. — There shall be a provision as follows:

“Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.”

History.

1961, ch. 330, § 503, p. 645.

§ 41-2115. Legal actions. — There shall be a provision as follows:

“Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.”

History.

1961, ch. 330, § 504, p. 645.

§ 41-2116. Change of beneficiary. — (1) There shall be a provision as follows:

“Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.”

(2) The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer’s option.

History.

1961, ch. 330, § 505, p. 645.

§ 41-2117. Optional policy provisions. — Except as provided in section 41-2104(2)[, Idaho Code], no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in sections 41-2118 to 41-2127[, Idaho Code], inclusive, of this chapter unless such provisions are in the words in which the same appear in the applicable section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the director which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the director may approve.

History.

1961, ch. 330, § 506, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in the first sentence were added by the compiler to conform to the statutory citation style.

§ 41-2118. Change of occupation. — There may be a provision as follows:

“Change of Occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.”

History.

1961, ch. 330, § 507, p. 645.

§ 41-2119. Misstatement of age. — There may be a provision as follows:

“Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.”

History.

1961, ch. 330, § 508, p. 645.

§ 41-2120 — 41-2122. Other insurance in this insurer — Insurance with other insurers — Provision of service or expense incurred basis — Other benefits. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised 1961, ch. 330, §§ 509 to 511, p. 645, were repealed by S.L. 1997, ch. 319, § 4, effective July 1, 1997.

§ 41-2123. Relation of earnings to insurance. — (1) There may be a provision as follows:

“Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of \$200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.”

(2) The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (a) until at least age fifty (50), or (b) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue. The insurer may, at its option, include in this provision a definition of “valid loss of time coverage”, approved as to form by the director, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the director or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen’s [worker’s]

compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

History.

1961, ch. 330, § 512, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of subsection (2) was added by the compiler to reflect the current provisions of Title 72, Idaho Code.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2124. Unpaid premiums. — There may be a provision as follows:

“Unpaid Premiums: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.”

History.

1961, ch. 330, § 513, p. 645.

§ 41-2125. Conformity with state statutes. — There may be a provision as follows:

“Conformity with State Statutes: Any provision of this policy which, on its effective date is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.”

History.

1961, ch. 330, § 514, p. 645.

§ 41-2126. Illegal occupation. — There may be a provision as follows:

“Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured’s commission of or attempt to commit a felony or to which a contributing cause was the insured’s being engaged in an illegal occupation.”

History.

1961, ch. 330, § 515, p. 645.

RESEARCH REFERENCES

ALR. — Liability under accident policy not containing a “violation of law” clause, for death or injury resulting from violation of law by insured.
[43 A.L.R.3d 1120.](#)

§ 41-2127. Intoxicants and narcotics. — There may be a provision as follows:

“Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured’s being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.”

History.

1961, ch. 330, § 516, p. 645.

§ 41-2128. Renewability. — Disability insurance policies, other than accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, shall provide in substance in a provision thereof or in an endorsement thereon or rider attached thereto that subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement), and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. (The parenthetical reference to lapse and reinstatement may be omitted at the insurer's option.)

History.

1961, ch. 330, § 517, p. 645.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2129. Order of certain provisions. — The provisions which are the subject of sections 41-2105 to 41-2127[, Idaho Code], inclusive, of this chapter, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided that the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

History.

1961, ch. 330, § 518, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the beginning of the section was added by the compiler to conform to the statutory citation style.

§ 41-2130. Third party ownership. — The word “insured”, as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

History.

1961, ch. 330, § 519, p. 645.

§ 41-2131. Requirements of other jurisdictions. — (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state or country under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

History.

1961, ch. 330, § 520, p. 645.

§ 41-2132. Policies issued for delivery in another state. — If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance director or corresponding public official of such other state has informed the director that any such policy is not subject to approval or disapproval by such official, the director may by ruling require that the policy meet the standards set forth in section 41-2103[, Idaho Code,] and in sections 41-2104 to 41-2131[, Idaho Code], inclusive.

History.

1961, ch. 330, § 521, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions near the end of the section were added by the compiler to conform to the statutory citation style.

§ 41-2133. Conforming to statute. — (1) No policy provision which is not subject to this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(2) A policy delivered or issued for delivery to any person in this state in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this chapter.

History.

1961, ch. 330, § 522, p. 645.

CASE NOTES

Cited *Goodwin v. Nationwide Ins. Co.*, 104 Idaho 74, 656 P.2d 135 (Ct. App. 1982).

§ 41-2134. Age limit. — If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

History.

1961, ch. 330, § 523, p. 645.

§ 41-2135. Prohibited policy plans — Provisions. — No insurer shall hereafter deliver or issue for delivery in this state any disability insurance policy:

(1) Providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination of the policies of other policyholders whether by death or otherwise.

(2) Containing any clause, provision or agreement providing a premium, deposit or other payment for, or promising the distribution of, any bonus, special fund, or guaranteed payment other than the insurance benefits specified in the policy. This restriction shall not be construed to apply to the payment of dividends to the holders of participating policies.

History.

1961, ch. 330, § 524, p. 645.

§ 41-2136. Filing of rates. — Each insurer issuing disability insurance policies for delivery in this state shall, before use thereof, file with the director its premium rates and classification of risks pertaining to such policies. The insurer shall adhere to its rates and classifications as filed with the director. The insurer may change such filings from time to time as it deems proper. This section shall not apply to the premium rates or classifications of risks for policies subject to chapter 47 or 52, title 41, Idaho Code.

History.

1961, ch. 330, § 525, p. 645; am. 1995, ch. 360, § 1, p. 1235.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2137. Franchise Disability Insurance Law. — Disability insurance on a franchise plan is hereby declared to be that form of disability insurance issued to:

(1) Four (4) or more employees of any corporation, copartnership, or individual employer or any governmental corporation, agency or department thereof; or

(2) Ten (10) or more members, employees or employees of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two years where such association or union has a constitution or by-laws and is formed in good faith for purposes other than that of obtaining insurance; where such persons with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by such persons under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association or union for its members, or by some designated person acting on behalf of such employer or association or union. The term “employees” as used herein may be deemed to include the officers, managers and employees and retired employees of the employer and the individual proprietor or partnership.

History.

1961, ch. 330, § 526, p. 645.

§ 41-2138. Health insurance — Ten-day free examination. — (1) Except as to nonrenewable accident policies and individual credit health insurance policies, every individual health insurance policy shall contain a provision therein or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten (10) days of its delivery to such person and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. The provision shall be set forth in the policy under appropriate caption, and if not so printed on the face page of the policy adequate notice of the provision shall be printed or stamped conspicuously on the face page.

(2) The policy may be so returned to the insurer at its home or branch office or to the agent through whom it was applied for, and thereupon shall be void as from the beginning and as if the policy had not been issued.

History.

I.C., § 41-2138, as added by 1969, ch. 214, § 58, p. 625.

§ 41-2139. Required provisions — Coverage of dependent child. —

There shall be a provision as follows: a policy delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of this act under which coverage of a dependent of an insured terminates at a specified age shall, with respect to an unmarried child who is incapable of self-sustaining employment by reason of intellectual disability or physical disability and who became so incapable prior to attainment of the limiting age and who is chiefly dependent upon such insured for support and maintenance, not so terminate while the policy remains in force and the dependent remains in such condition, if the insured has within thirty-one (31) days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After the two (2) year period, such subsequent proof may not be required more than once each year.

History.

I.C., § 41-2139, as added by 1972, ch. 348, § 2, p. 1030; am. 2010, ch. 235, § 32, p. 542.

STATUTORY NOTES

Amendments.

The 2010 amendment, by ch. 235, substituted “employment by reason of intellectual disability or physical disability” for “employment by reason of mental retardation or physical handicap” in the first sentence.

Compiler's Notes.

The phrase “the effective date of this act” refers to the effective date of S.L. 1972, Chapter 348, which was effective July 1, 1972.

§ 41-2140. Required provisions. — (1) Any disability insurance contract delivered or issued for delivery in this state which provides coverage for injury or sickness for newborn dependent children of the insured, shall provide such coverage for such newborn children, including adopted newborn children that are placed with the adoptive insured within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive insured more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive insured, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive insured signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with an insured continues in the same manner as it would with respect to a naturally born child of the insured until the first to occur of the following events:

- (a) Date the child is removed permanently from that placement and the legal obligation terminates; or
- (b) The date the insured rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) An insurer shall not restrict coverage under a disability insurance policy of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement

for adoption occurs which the participant or beneficiary is eligible for coverage under the plan.

(3) No policy of disability insurance which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the policy. If a fixed amount is specified in such policy for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the policy. Where the policy contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the policy. This section shall apply to all disability policies except individual noncancelable or guaranteed renewable policies, issued or delivered before January 1, 1977.

With respect to such individual noncancelable or guaranteed renewable policies issued or delivered before January 1, 1977, the insurer shall communicate the availability of coverage of involuntary complications of pregnancy when negotiating any changes in such policies.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All policies subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such policy which is in conflict with this section shall be of no force or effect.

(4) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits, shall restrict benefits for any hospital length of stay in connection with childbirth for the mother

or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

History.

I.C., § 41-2140, as added by 1974, ch. 66, § 2, p. 1146; 1976, ch. 113, § 1, p. 443; am. 1993, ch. 305, § 1, p. 1129; am. 1994, ch. 365, § 2, p. 1144; am. 1997, ch. 321, § 1, p. 948.

STATUTORY NOTES

Federal References.

The Newborns' and Mothers' Health Protection Act of 1996, referred to in subsection (4) of this section, is compiled as 29 USCS §§ 1003, 1021, 1022, 1024, 1132, 1136, 1144, 1181, 1191, and 1191a and 42 U.S.C.S., §§ 201 note, 300gg-4, 300gg-21, 300gg-23, 300gg-44, 300gg-51, and 300gg-61 to 300gg-63.

Effective Dates.

Section 5 of S.L. 1974, ch. 66 provided that the act take effect on and after July 1, 1974.

Section 6 of S.L. 1976, ch. 113 provided that the act take effect on and after January 1, 1977.

§ 41-2141. Coordination of benefits — Coordination with social security benefits. — (1) Under the authority of this section and [section 41-2216, Idaho Code](#), the director shall promulgate rules that are in accordance with the model regulations of the national association of insurance commissioners relating to coordination of benefits provisions in individual and group disability insurance policies. This section shall apply to all policies of individual disability insurance or coverage issued in this state pursuant to the provisions of chapters 21, 34, 39 and 52, title 41, Idaho Code. These rules shall establish uniformity in the permissive use of provisions governing the coordination of benefits between individual disability policies and between individual disability policies and group disability policies in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions.

(2) Any provision contained in a policy of disability insurance providing for a reduction of benefits payable under the policy during a policy benefit period due to an increase in benefits payable under the federal social security act, as amended, shall be null and void with respect to any such increase which occurs on or after the effective date of this act.

History.

[I.C., § 41-2141](#), as added by 1978, ch. 10, § 1, p. 19; am. 1997, ch. 319, § 1, p. 942.

STATUTORY NOTES

Federal References.

The federal social security act, referred to in subsection (2), is compiled as title [42 U.S.C.S. § 301 et seq.](#)

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (1), see <http://naic.org>.

The phrase “the effective date of this act” at the end of the section refers to the effective date of S.L. 1978, Chapter 10, which was effective July 1,

1978.

§ 41-2142. Limitation of benefits for elective abortions. — All policies, contracts, plans or certificates of disability insurance delivered, issued for delivery or renewed in this state after the effective date of this section shall exclude coverage for elective abortions. Such exclusion may be waived by endorsement and the payment of a premium therefor. Availability of such coverage shall be at the option of the insurance carrier. For purposes of this section, an “elective abortion” means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

History.

I.C., § 41-2142, as added by 1983, ch. 94, § 1, p. 206.

STATUTORY NOTES

Compiler’s Notes.

The phrase “the effective date of this section” in the first sentence refers to the effective date of the enactment of this section by S.L. 1983, Chapter 94, which was effective July 1, 1983.

§ 41-2143. Services provided by governmental entities. — (1) From and after July 1, 1990, no disability insurance policy shall be issued in Idaho which excludes from coverage services rendered the insured while a resident in an Idaho state institution, provided the services to the insured would be covered by the disability insurance policy if rendered to him outside an Idaho state institution.

(2) From and after July 1, 1990, no disability insurance policy shall be issued in Idaho which contains any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a policy which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of insurance coverage.

History.

I.C., § 41-2143, as added by 1990, ch. 300, § 1, p. 827.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

§ 41-2144. Mammography coverage. — (1) From and after July 1, 1992, all disability contracts which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:

- (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
- (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
- (c) A mammogram every year for any woman who is fifty (50) years of age or older.
- (d) A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

History.

I.C., § 41-2144, as added by 1992, ch. 132, § 1, p. 413; am. 1993, ch. 113, § 1, p. 288.

STATUTORY NOTES

Effective Dates.

Section 6 of S.L. 1993, ch. 113 provided that the act shall be in full force and effect on July 1, 1993.

**§ 41-2145. Health insurance coverage for dependent children.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-2145, as added by 1994, ch. 365, § 3, p. 1144; am. 1998, ch. 292, § 22, p. 928, was repealed by S.L. 2003, ch. 304, § 1, effective July 1, 2003.

§ 41-2146. Coverage provided to persons having insurance. — An insurer providing individual disability insurance coverage in this state shall make available to citizens of this state major medical disability policies under the terms set forth in this section. An insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation, or automobile medical payment insurance is not required to comply with the provisions of this section. An insurer providing only specified disease or hospital confinement indemnity insurance in this state shall not be required to comply with the provisions of this section, provided the insurance is marketed as supplemental health insurance and not as a substitute for hospital or major medical expense insurance, and the insurer certifies annually to the director that the insurance is being marketed in a manner consistent with the provisions of this subsection.

(2) As used in this section, the term “major medical disability policies” means policies, including medicare supplement insurance policies, contracts or certificates which are issued to provide hospital and medical-surgical coverage.

(3) Each insurer offering or maintaining individual major medical disability policies in this state shall make current individual policies available to an individual or dependent of an individual currently insured by the insurer, without imposition by the insurer of underwriting criteria whereby coverage of an individual or a dependent of an individual is denied or subject to cancellation or nonrenewal, in whole or in part because of the individual's age, health or medical history or employment status, or, if employed, industry or job classification if the individual is insured with that insurer and wishes to convert coverage to another policy, plan or contract. When offering benefits pursuant to this section, the insurer shall be required to offer equal or lesser benefits than the insured has under the existing policy or plan. If the insurer offers benefits in excess of what was included in the insurer's contract to the insured, the insurer may impose health underwriting criteria and a preexisting condition clause which will waive all or a portion of benefits offered for the first twelve (12) months of the policy for a condition which has occurred during the preceding twelve (12)

months. The preexisting condition clause herein authorized may not be applied to the transfer from one (1) medicare supplement policy, contract or certificate to another where benefits are increased. As used herein, “benefits in excess of what was included in the insured’s contract” shall include but not be limited to lower deductibles, lower coinsurance or copayments or lower maximum out-of-pocket expenditure for health care. The addition of pharmacy cards to replace existing prescription drug benefits, supplemental accident insurance, chiropractic services or vision services shall not constitute “benefits in excess of what was included in the insured’s contract.”

In implementing the provisions of this section, the director shall provide that insurers shall provide insureds with a simplified application that shall not exceed one (1) page in length and which shall not exceed six (6) medical questions.

History.

I.C., § [41-2146] 41-2145, as added by 1994, ch. 404, § 1, p. 1268; am. and redesign. 1995, ch. 254, § 1, p. 831.

STATUTORY NOTES

Compiler’s Notes.

This section was enacted by S.L. 1994, ch. 404, § 1 which designated the section permanently as § 41-2145; however, since another 1994 act (ch. 365, § 3) also enacted a section designated as § 41-2145, this section was temporarily compiled as § 41-2146. Section 1 of S.L. 1995, ch. 254 amended and redesignated the section enacted by S.L. 1997, ch. 365, § 2 permanently as § 41-2146.

Effective Dates.

Section 4 of S.L. 1994, ch. 404 provided that this act shall be in full force and effect on and after January 1, 1995.

Chapter 22

GROUP AND BLANKET DISABILITY INSURANCE

Sec.

41-2201. Scope of chapter — Short title.

41-2202. “Group disability insurance” defined — Eligible groups.

41-2203. Required provisions in group policies.

41-2204. Direct payment of hospital and medical services.

41-2205. Readjustment of premiums — Dividends.

41-2206. “Blanket disability insurance” defined.

41-2207. Required provisions in blanket policies.

41-2208. Application and certificates not required.

41-2209. Payment of benefits under blanket policy.

41-2210. Required provision in group and blanket policies.

41-2210A. Limitation of benefits for elective abortions.

41-2210D. Conversion plan — When required.

41-2211. Scope of act — Replacement of group disability insurance, group nonprofit hospital and medical service contracts and health care service plans.

41-2212. Definitions.

41-2213. Policy standards — Disabled individuals.

41-2214. Policy standards — Maternity benefits.

41-2215. Policy standards — Replacement contracts.

41-2216. Coordination of benefits — Coordination with social security benefits.

41-2217. Services provided by governmental entities.

41-2218. Mammography coverage.

41-2219. Health insurance coverage for dependent children. [Repealed.]

41-2220. Coverage provided to persons having insurance.

41-2221. Crediting of preexisting condition waiting period.

41-2222. [Reserved.]

41-2223. Renewability of coverage.

§ 41-2201. Scope of chapter — Short title. — (1) This chapter applies only to group disability insurance contracts and to blanket disability insurance contracts as herein provided for.

(2) This chapter may be cited as the “group or blanket disability insurance law”.

History.

1961, ch. 330, § 527, p. 645.

§ 41-2202. “Group disability insurance” defined — Eligible groups.

— “Group disability insurance” is hereby declared to be that form of disability insurance covering groups of persons as defined below, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. The term “employees” as used herein shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term “employees” as used herein may include retired employees. A policy issued to insure employees of a public body may provide that the term “employees” shall include elected or appointed officials. The policy may provide that the term “employees” shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(2) Under a policy issued to an association, including a labor union, which shall have a constitution and by-laws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term “employees” as used herein may include retired employees.

(3) Under a policy issued to the trustees of a fund established by two (2) or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an

association as defined in subdivision (2) above, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or of such association, or employees of members of such association, for the benefit of persons other than the employers or the unions or such association. The term “employees” as used herein may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term “employees” as used herein may include retired employees. The policy may provide that the term “employees” shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under such group life policy.

(5) Under a policy issued to cover any other substantially similar group which, in the discretion of the director, may be subject to the issuance of a group disability policy or contract.

(6) Any group disability policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

History.

1961, ch. 330, § 528, p. 645.

STATUTORY NOTES

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2203. Required provisions in group policies. — Each such group disability insurance policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

(2) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group, a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one (1) certificate need be issued for each family unit.

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) A provision that, a policy delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of this act under which coverage of a dependent of a member of an insured group terminates at a specified age shall, with respect to an unmarried child who is incapable of self-sustaining employment by reason of intellectual disability or physical disability and who became so incapable prior to attainment of the limiting age and who is chiefly dependent upon such member for support and maintenance, not so terminate while the policy remains in force and the dependent remains in such condition, if the member has within thirty-one (31) days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The insurer may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the

child's disability and dependency. After the two (2) year period, such subsequent proof may not be required more than once each year.

History.

1961, ch. 330, § 529, p. 645; am. 1972, ch. 348, § 3, p. 1030; am. 2010, ch. 235, § 33, p. 542.

STATUTORY NOTES

Amendments.

The 2010 amendment, by ch. 235, in subsection (4), substituted “employment by reason of intellectual disability or physical disability” for “employment by reason of mental retardation or physical handicap.”

Compiler's Notes.

The phrase “the effective date of this act” in the first sentence in subsection (4) refers to the effective date of S.L. 1972, Chapter 348, which was effective July 1, 1972.

CASE NOTES

Contents of Coverage Booklet.

An insured must be entitled to rely upon the coverage booklet with which he is furnished; accordingly, the insurer cannot be in compliance with the statutory requirements of this section and § 41-3417 and at the same time render that compliance nugatory by inserting a disclaimer which has the effect of settling a controversy as to coverage in its favor by declaring contrary policy provisions paramount over the statements of coverage set forth in the issued booklet. [Linn v. North Idaho Dist. Medical Serv. Bureau, Inc., 102 Idaho 679, 638 P.2d 876 \(1981\).](#)

§ 41-2204. Direct payment of hospital and medical services. — Any group disability policy may provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

History.

1961, ch. 330, § 530, p. 645.

§ 41-2205. Readjustment of premiums — Dividends. — Any contract of group disability insurance may provide for the readjustment of the rate of premium based upon the experience thereunder. If a policy dividend is hereafter declared or a reduction in rate is hereafter made or continued for the first or any subsequent year of insurance under any policy of group disability insurance heretofore or hereafter issued to any policyholder, the excess, if any, of the aggregate dividends or rate reductions under such policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under such policies made from funds contributed by the policyholder, or by an employer or insured persons, or by a union or association to which the insured persons belong, including expenditures made in connection with administration of such policies, shall be applied by the policyholder for the sole benefit of insured employees or members.

History.

1961, ch. 330, § 531, p. 645.

§ 41-2206. “Blanket disability insurance” defined. — “Blanket disability insurance” is hereby declared to be that form of disability insurance covering groups of persons as enumerated in one of the following subdivisions.

(1) Under a policy or contract issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group defined as all persons or all persons of a class who may become passengers on such common carrier or such means of transportation.

(2) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering the employer and all employees, dependents or guests, defined by reference to specified hazards incident to the activities or operations of the employer or any class of employees, dependents or guests similarly defined.

(3) Under a policy or contract issued to a school, or other institution of learning, camp or sponsor thereof; or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers. Supervisors and employees may be included.

(4) Under a policy or contract issued in the name of any religious, charitable, recreational, educational, or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization.

(5) Under a policy or contract issued to a sports team or sponsors thereof which shall be deemed the policyholder, covering members, officials and supervisors.

(6) Under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of such fire department or group.

(7) Under a policy or contract issued to cover any other risk or class of risks which, in the discretion of the director may be properly eligible for

blanket disability insurance. The discretion of the director may be exercised on an individual risk basis or class of risks, or both.

History.

1961, ch. 330, § 532, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2207. Required provisions in blanket policies. — Any insurer authorized to write disability insurance in this state shall have the power to issue blanket disability insurance. No such blanket policy may be issued or delivered in this state unless a copy of the form thereof shall have been filed in accordance with section 41-1812[, Idaho Code]. Every such blanket policy shall contain provisions which in the opinion of the director are at least as favorable to the policyholder and the individual insured as the following:

(1) A provision that the policy and the application shall constitute the entire contract between the parties, and that all statements made by the policyholder shall, in absence of fraud, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless it is contained in a written application.

(2) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within thirty (30) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety (90) days

after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of thirty (30) days during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make any autopsy in case of death where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

History.

1961, ch. 330, § 533, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of the second sentence in the introductory paragraph was added by the compiler to conform to the statutory citation style.

§ 41-2208. Application and certificates not required. — An individual application shall not be required from a person covered under a blanket disability policy or contract, nor shall it be necessary for the insurer to furnish each such person a certificate of the insurance.

History.

1961, ch. 330, § 534, p. 645.

§ 41-2209. Payment of benefits under blanket policy. — All benefits under any blanket disability policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate; except, that if the person insured be a minor or mental incompetent, such benefits may be made payable to his parent, guardian, or other person actually supporting him; or if the entire cost of the insurance has been borne by the employer such benefits may be made payable to the employer. Provided, however, that the policy may provide that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

History.

1961, ch. 330, § 535, p. 645.

§ 41-2210. Required provision in group and blanket policies. — (1) Any group disability insurance contract or blanket disability insurance contract, delivered or issued for delivery in this state which provides coverage for injury or sickness for newborn dependent children of subscribers or other members of the covered group, shall provide coverage for such newborn children, including adopted newborn children that are placed with the adoptive subscriber or other member of the covered group within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive subscriber or other member of the covered group more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive subscriber or other member of the covered group, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive subscriber or other member of the covered group signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a subscriber or other member of the covered group continues in the same manner as it would with respect to a naturally born child of the subscriber or other member of the covered group until the first to occur of the following events:

- (a) Date the child is removed permanently from that placement and the legal obligation terminates; or
- (b) The date the subscriber or other member of the covered group rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) An insurer shall not restrict coverage under a group disability insurance contract or a blanket disability insurance contract of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of a child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) Any new or renewing group disability insurance contract or blanket disability insurance contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half ($\frac{1}{2}$) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

(4) No policy of disability insurance which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the policy. If a fixed amount is specified in such policy for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the policy. Where the policy contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the policy. This section shall apply to all disability policies except any group disability policy made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All policies subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such policy which is in conflict with this section shall be of no force or effect.

(5) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits, shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

History.

I.C., § 41-2210, as added by 1974, ch. 66, § 3, p. 1146; am. 1976, ch. 113, § 2, p. 443; am. 1993, ch. 305, § 2, p. 1129; am. 1994, ch. 365, § 4, p. 1144; am. 1997, ch. 321, § 2, p. 948; am. 2008, ch. 296, § 1, p. 825; am. 2009, ch. 125, § 2, p. 391.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 296, added subsection (3) and redesignated the subsequent subsections accordingly.

The 2009 amendment, by ch. 125, rewrote the first sentence in subsection (3), which formerly read: "Any group disability insurance contract or blanket disability insurance contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-one (21) years or an unmarried child who is a full-time student under the age of twenty-five (25) years and who is financially dependent upon the parent shall be permitted to remain on the parent's or parents' contract."

Federal References.

The newborns' and mothers' health protection act of 1996, referred to in subsection (5) of this section, is compiled as 29 USCS §§ 1003, 1021, 1022, 1024, 1132, 1136, 1144, 1181, 1191, and 1191a and 42 U.S.C.S., §§ 201

note, 300gg-4, 300gg-21, 300gg-23, 300gg-44, 300gg-51, and 300gg-61 to 300gg-63.

Effective Dates.

Section 6 of S.L. 1976, ch. 113 provided that the act take effect on and after January 1, 1977.

§ 41-2210A. Limitation of benefits for elective abortions. — All policies, contracts, plans or certificates of group or blanket disability insurance delivered, issued for delivery or renewed in this state after the effective date of this section shall exclude coverage for elective abortions. Such exclusion may be waived by endorsement and the payment of a premium therefor. Availability of such coverage shall be at the option of the insurance carrier. For purposes of this section, an “elective abortion” means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

History.

I.C., § 41-2210A, as added by 1983, ch. 94, § 2, p. 206.

STATUTORY NOTES

Compiler’s Notes.

The phrase “the effective date of this section” in the first sentence refers to the effective date of the enactment of this section by S.L. 1983, Chapter 94, which was effective July 1, 1983.

§ 41-2210D. Conversion plan — When required. — Any group carrier doing business in the state of Idaho that does not have an individual product on file with the department of insurance shall provide a conversion plan to all group insureds. The conversion plan shall provide benefits at least equal to the standard health benefit plan developed pursuant to [section 41-4712, Idaho Code](#). The premium under the plan shall not exceed one hundred twenty-five percent (125%) of the index rate for groups.

History.

[I.C., § 41-2210D](#), as added by 1996, ch. 124, § 1, p. 438.

§ 41-2211. Scope of act — Replacement of group disability insurance, group nonprofit hospital and medical service contracts and health care service plans. — The provisions of this act shall apply to all policies of group disability insurance issued in this state pursuant to the provisions of chapter 22, title 41, Idaho Code, and any group nonprofit hospital and medical service contract issued in this state pursuant to the provisions of chapter 34, title 41, Idaho Code, and all group health care service plans issued in this state pursuant to chapter 39, title 41, Idaho Code.

History.

1975, ch. 204, § 2, p. 565.

STATUTORY NOTES

Legislative Intent.

Section 1 of S.L. 1975, ch. 204 read: “Intent and purpose. — The purpose of this act is to provide reasonable standards of benefits for covered individuals when the group disability policies, contracts or plans under which they are covered are replaced.”

Compiler’s Notes.

The term “this act” near the beginning of this section refers to S.L. 1975, Chapter 204, which is compiled as §§ 41-2211 to 41-2215.

CASE NOTES

Cited *Linn v. North Idaho Dist. Medical Serv. Bureau, Inc.*, 102 Idaho 679, 638 P.2d 876 (1981).

§ 41-2212. Definitions. — In this act, unless the context otherwise requires:

(1) “Carrier” shall mean the insurance company, nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a policy.

(2) “Dependent” shall have the meaning set forth in a policy.

(3) “Discontinuance” shall mean the termination of a policy by action taken by the policy holder, including failure to pay premium within the period provided by the policy, or by the carrier pursuant to a provision of the policy permitting termination or by mutual agreement of the policyholder and carrier.

(4) “Employee” shall mean all agents, employees, and members of unions or associations to whom benefits are provided under a policy.

(5) “Extension of Benefits” means the continuation of coverage under a particular benefit provided under a policy following discontinuance with respect to an employee or dependent who is totally disabled on the date of discontinuance.

(6) “Policy” shall mean any group insurance policy, group hospital and medical service contract or other plan, contract or policy subject to the provisions of this act.

(7) “Policyholder” shall mean the entity to which a policy is issued as specified in section 41-2213[, Idaho Code].

(8) “Premium” shall mean the consideration payable to the carrier.

(9) “Replacement Coverage” shall mean the benefits which are substituted under one carrier’s policy by similar benefits under a policy issued by another carrier.

(10) “Totally Disabled” shall have the meaning set forth in a policy and not be inconsistent with the definition of “disability insurance” in [section 41-503, Idaho Code](#).

History.

1975, ch. 204, § 3, p. 565.

STATUTORY NOTES

Compiler's Notes.

The term “this act” in the introductory paragraph and in subsection (6) refer to S.L. 1975, Chapter 204, which is compiled as §§ 41-2211 to 41-2215.

The bracketed insertion in subsection (7) was added by the compiler to conform to the statutory citation style.

§ 41-2213. Policy standards — Disabled individuals. — Every policy containing the benefits described in subsections (1), (2) and (3) of this section must contain a provision which provides for a reasonable extension of benefits with respect to employees or dependents who become totally disabled after the effective date of this act and continue to be totally disabled at the date of discontinuance of the policy. Such an extension of benefits provision will be deemed a reasonable extension of benefits provision if it complies with the standards set forth in subsections (1), (2) and (3) of this section.

(1) In the case of a policy providing benefits for loss of time or a specific indemnity during hospital confinement, the extension of benefits provision will be deemed reasonable if continuance does not affect the benefit provided.

(2) In the case of a policy providing hospital, medical or surgical expense coverage, the extension of benefits provision will be deemed reasonable if it provides benefits for covered expenses incurred as the result of the disabling condition beyond the date of discontinuance for a period of not less than twelve (12) months.

(3) In the case of a policy providing loss by dismemberment, the extension of benefits provision will be deemed reasonable if it provides benefits for dismemberment loss that occurs after termination of policy that was a result of a disabling condition that occurred while the policy was in effect. Benefits for any such loss will be payable under the policy, in accordance with its limitations, exceptions and provisions as if this policy had not been so terminated.

The benefits payable during any extension of benefits may be subject to all limitations or restrictions contained in the policy. Any extension of benefits may be terminated at such time as the employee or dependent is no longer totally disabled.

History.

1975, ch. 204, § 4, p. 565; am. 1978, ch. 8, § 1, p. 14.

STATUTORY NOTES

Compiler's Notes.

The phrase “the effective date of this act” in the first sentence in the introductory paragraph refers to the effective date of S.L. 1975, Chapter 204, which was effective July 1, 1975.

§ 41-2214. Policy standards — Maternity benefits. — If a policy provides any benefits for pregnancy, childbirth or miscarriage and if an employee or dependent covered for such benefit is pregnant at the time of discontinuance and is not eligible for any replacement group coverage within sixty (60) days of discontinuance, the policy must provide that benefits will be payable to the same extent as if discontinuance had not occurred for any covered benefits in connection with such pregnancy, childbirth or miscarriage, but not beyond a period of twelve (12) months following such discontinuance.

History.

1975, ch. 204, § 5, p. 565; am. 2001, ch. 129, § 1, p. 451.

§ 41-2215. Policy standards — Replacement contracts. — (1) Any carrier providing replacement coverage with respect to hospital, medical or surgical expense benefits within a period of sixty (60) days from the date of discontinuance of a prior policy providing such hospital, medical or surgical expense benefits shall immediately cover all employees and dependents validly covered under the previous policy at the date of discontinuance who are within the definitions of eligibility and who would otherwise be eligible for coverage under the succeeding carrier's policy, regardless of any limitations or exclusions relating to active employment or nonconfinement.

(2) With respect to an employee or dependent who was totally disabled on the date of discontinuance of the prior carrier's policy and required to be covered under subsection (1) of this section, the succeeding carrier shall be entitled to deduct from any benefits becoming payable under its policy the amount of benefits payable by the prior carrier pursuant to an extension of benefits provision.

(3) An employee or dependent entitled to coverage under a succeeding carrier's policy pursuant to subsection (1) or (2) of this section shall continue to be covered by the succeeding carrier until the earlier of the following:

(a) The date coverage would terminate for an employee or dependent in accordance with the provisions of the succeeding carrier's policy; or

(b) In the case of an employee or dependent who was totally disabled on the date of discontinuance of the prior carrier's policy and entitled to an extension of benefits pursuant to subsection (2) of section 41-2213[, Idaho Code], the date the period of extension of benefits terminates or, if the prior carrier's policy is not subject to this act, the date to which benefits would have been extended had the prior carrier's policy been subject to this act.

(4) No provision in a succeeding carrier's policy of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's policy shall be applied with respect to those employees

and dependents validly insured under the prior carrier's policy on the date of discontinuance, if benefits for such condition would have been payable under the prior carrier's policy.

(5) In a situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of benefits available or pertinent information, sufficient to permit verification of the benefit determination by the succeeding carrier, at no cost.

History.

1975, ch. 204, § 6, p. 565; am. 2003, ch. 307, § 1, p. 843.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in paragraph (3)(b) was added by the compiler to conform to the statutory citation style.

The term "this act" in paragraph (3)(b) refers to S.L. 1975, Chapter 204, which is compiled as §§ 41-2211 to 41-2215.

Section 7 of S.L. 1975, ch. 204 read: "The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

Effective Dates.

Section 8 of S.L. 1975, ch. 204 provided that the act should take effect on and after July 1, 1975.

§ 41-2216. Coordination of benefits — Coordination with social security benefits. — (1) Under the authority of this section and [section 41-2141, Idaho Code](#), the director shall promulgate rules that are in accordance with the model regulations of the national association of insurance commissioners relating to coordination of benefits provisions in group and individual disability insurance policies. This section shall apply to all policies of group disability insurance or coverage issued in this state pursuant to the provisions of chapters 22, 34, 39 and 47, title 41, Idaho Code. These rules shall establish uniformity in the permissive use of provisions governing the coordination of benefits between group disability policies and between group disability policies and individual disability policies in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions.

(2) Any provision contained in a policy of group or blanket disability insurance providing for a reduction of benefits payable under the policy during a policy benefit period due to an increase in benefits payable under the federal social security act, as amended, shall be null and void with respect to any such increase which occurs on or after the effective date of this act.

History.

[I.C., § 41-2216](#), as added by 1978, ch. 10, § 2, p. 19; am. 1989, ch. 143, § 1, p. 348; am. 1997, ch. 319, § 2, p. 942.

STATUTORY NOTES

Federal References.

The federal social security act, referred to in subsection (2), is compiled as [42 U.S.C.S. § 301 et seq.](#)

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (1), see <http://naic.org>.

The phrase “the effective date of this act” at the end of the section refers to the effective date of S.L. 1978, Chapter 10, which was effective July 1, 1978.

§ 41-2217. Services provided by governmental entities. — (1) From and after July 1, 1990, no group or blanket disability insurance policy shall be issued in Idaho which excludes from coverage services rendered the insured while a resident in an Idaho state institution, provided the services to the insured would be covered by the policy if rendered to him outside an Idaho state institution.

(2) From and after July 1, 1990, no group or blanket disability insurance policy may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a policy which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of insurance coverage.

History.

I.C., § 41-2217, as added by 1990, ch. 300, § 2, p. 827.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

§ 41-2218. Mammography coverage. — (1) From and after July 1, 1992, all group or blanket disability insurance policies which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:

- (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
- (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
- (c) A mammogram every year for any woman who is fifty (50) years of age or older.
- (d) A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

History.

I.C., § 41-2218, as added by 1992, ch. 132, § 2, p. 413; am. 1993, ch. 113, § 2, p. 288.

STATUTORY NOTES

Effective Dates.

Section 6 of S.L. 1993, ch. 113 provided that the act shall be in full force and effect on July 1, 1993.

**§ 41-2219. Health insurance coverage for dependent children.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-2219, as added by 1994, ch. 365, § 5, p. 1144; am. 1998, ch. 292, § 23, p. 928, was repealed by S.L. 2003, ch. 304, § 1.

§ 41-2220. Coverage provided to persons having insurance. — [(1)] An insurer providing group disability insurance coverage in this state shall make available to citizens of this state current major medical disability benefit policies under the terms set forth in this section. An insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation, or automobile medical payment insurance is not required to comply with the provisions of this section. An insurer providing only specified disease or hospital confinement indemnity insurance in this state shall not be required to comply with the provisions of this section, provided the insurance is marketed as supplemental health insurance and not as a substitute for hospital or major medical expense insurance, and the insurer certifies annually to the director that the insurance is being marketed in a manner consistent with the provisions of this subsection.

(2) As used in this section, the term "major medical disability policies" means policies, including medicare supplement insurance policies, contracts or certificates which are issued to provide hospital and medical-surgical coverage.

(3) Each insurer offering or maintaining group major medical disability policies in this state shall make a current group or individual policy available to an individual or dependent of an individual currently under group coverage by the insurer following expiration or the insured's declination of COBRA benefit coverage, if applicable, or otherwise upon termination of group coverage, without imposition by the insurer of underwriting criteria whereby coverage of an individual or a dependent of an individual is denied or subject to cancellation or nonrenewal, in whole or in part because of the individual's age, health or medical history or employment status, or, if employed, industry or job classification if the individual is insured with that insurer and wishes to convert coverage to another policy, plan or contract. When offering benefits pursuant to this section, the insurer shall be required to offer equal or lesser benefits than the insured has under the existing policy with the company. If the insurer offers benefits in excess of what was included in the insurer's contract to the

insured, the insurer may impose health underwriting criteria and a preexisting condition clause which will waive all or a portion of benefits offered for the first twelve (12) months of the policy for a condition which has occurred during the preceding twelve (12) months. The preexisting condition clause herein authorized may not be applied to the transfer from one (1) medicare supplement policy, contract or certificate to another where benefits are increased. As used herein, “benefits in excess of what was included in the insured’s contract” shall include but not be limited to lower deductibles, lower coinsurance or copayments, or lower maximum out-of-pocket expenditure for health care. The addition of pharmacy cards to replace existing prescription drug benefits, supplemental accident insurance, chiropractic services or vision services shall not constitute “benefits in excess of what was included in the insured’s contract.”

In implementing the provisions of this section, the director shall provide that insurers shall provide insureds with a simplified application that shall not exceed one (1) page in length and which shall not exceed six (6) medical questions.

History.

I.C., § [41-2220] 41-2219, as added by 1994, ch. 404, § 2, p. 1268; am. and redesign. 1995, ch. 254, § 2, p. 831.

STATUTORY NOTES

Federal References.

For continuation coverage and additional standards for group health plans under the consolidated omnibus budget reconciliation act of 1985 (COBRA), referred to in subsection (3), see [29 USCS § 1161 et seq.](#)

Compiler’s Notes.

The bracketed insertion at the beginning of the first paragraph was added by the compiler to supply the designation missing from the original enactment.

This section was enacted by S.L. 1994, ch. 404, § 2 which designated it as § 41-2219; however, since another 1994 act (ch. 365, § 5) also enacted a section designated as § 41-2219, this section was temporarily compiled as §

41-2220. Section 2 of S.L. 1995, ch. 254 amended and redesignated this section permanently as § 41-2220.

Effective Dates.

Section 4 of S.L. 1994, ch. 404 provided that this act shall be in full force and effect on and after January 1, 1995.

§ 41-2221. Crediting of preexisting condition waiting period. — (1) Health benefit plans covering large employers shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(b) Genetic information shall not be considered as a condition described in subsection (1)(a) of this section in the absence of a diagnosis of the condition related to such information.

(c) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(d) A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan.

(2) As used in this section:

(a) "Health benefit plan" means any group hospital or medical policy or certificate, any group subscriber contract provided by a hospital or

professional service corporation, or group health maintenance organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(b) "Large employer" means any person, firm, corporation, partnership or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar year, employed no less than fifty-one (51) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

(c) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a large employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(i) The individual meets each of the following:

- a. The individual was covered under qualifying previous coverage at the time of the initial enrollment;
- b. The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage; and
- c. The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

(ii) The individual is employed by a large employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

- (iii) A court has ordered coverage be provided for a spouse or a minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order; or
 - (iv) The individual first becomes eligible.
- (d) "Qualifying previous coverage" and "qualifying existing coverage" means benefits or coverage provided under:
- (i) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefits risk pool, or any other similar publicly sponsored program; or
 - (ii) Any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society.
- (e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:
- (i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
 - (ii) In the case of a dependent's birth, as of the date of such birth; or
 - (iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

History.

I.C., § 41-2221, as added by 1996, ch. 145, § 1, p. 476; am. 1997, ch. 321, § 3, p. 948.

STATUTORY NOTES

Federal References.

For civilian health and medical program for uniformed services (CHAMPUS), see **10 USCS § 1071**.

For Indian health service programs, see [25 USCS § 1601 et seq.](#)

Effective Dates.

Section 2 of S.L. 1996, ch. 145 provided that the act shall be in full force and effect on and after January 1, 1997.

CASE NOTES

Cited [Primary Health Network v. State, 137 Idaho 663, 52 P.3d 307 \(2002\).](#)

§ 41-2222. [Reserved.]

§ 41-2223. Renewability of coverage. — (1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the employer, except in any of the following cases:

- (a) Nonpayment of the required premiums;
- (b) Fraud or intentional misrepresentation of material fact by the employer;
- (c) Noncompliance with the carrier's minimum participation requirements;
- (d) Noncompliance with the carrier's employer contribution requirements;
- (e) In the case of health benefit plans that are made available in the employer market only through one (1) or more associations, as defined in [section 41-2202, Idaho Code](#), the membership of an employer in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual;
- (f) The employer no longer meets the requirements of [section 41-2221\(2\)\(b\), Idaho Code](#);
- (g) The carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to large employers in this state. Unless otherwise authorized in advance by the department of insurance, a carrier may discontinue a product only after the product has been in use for at least thirty-six (36) consecutive months, provided the carrier may not discontinue more than twenty percent (20%) of its total number of employees and dependents in all lines of business in a twelve (12) month period. The carrier shall:

- (i) Provide advance written or electronic notice of its decision under this paragraph to the director;
 - (ii) Provide notice of the discontinuation to all affected employers and employees or dependents at least ninety (90) calendar days prior to the date the particular health benefit plan will be discontinued by the carrier, provided that notice to the director under the provisions of this paragraph shall be provided at least fourteen (14) calendar days prior to the notice to the affected employers;
 - (iii) Offer to each affected employer, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the carrier to large employers in this state; and
 - (iv) In exercising the option to discontinue the health benefit plan and in offering the option to purchase all other health benefit plans under the provisions of this paragraph, act uniformly without regard to:
 - 1. The claims experience of an affected employer;
 - 2. Any health status-related factor relating to any affected employee or dependent; or
 - 3. Any health status-related factor relating to any new employee or dependent who may become eligible for the coverage.
- (h) The carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to large employers in this state. In such a case the carrier shall:
- (i) Provide advance notice of its decision under this paragraph to the director in each state in which it is licensed; and
 - (ii) Provide notice of the decision not to renew coverage to all affected employers and to the director at least one hundred eighty (180) calendar days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected employers; or
- (i) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the director shall assist affected employers in finding replacement coverage.

(2) A carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(h) of this section shall be prohibited from writing new business in the large employer market in this state for a period of five (5) years from the date of notice to the director.

(3) In the case of a carrier doing business in one (1) established geographic service area of the state, the provisions set forth in this section shall apply only to the carrier's operations in that service area.

History.

I.C., § 41-2223, as added by 1997, ch. 321, § 4, p. 948; am. 2006, ch. 353, § 1, p. 1079.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 353, added paragraph (1)(g) and redesignated former paragraphs (1)(g) and (1)(h) as present (1)(h) and (1)(i).

Chapter 23

CREDIT LIFE AND CREDIT DISABILITY INSURANCE

Sec.

41-2301. Declaration of purpose.

41-2302. Short title.

41-2303. Scope of chapter.

41-2304. Definitions.

41-2305. Forms of credit life insurance and credit disability insurance.

41-2306. Amount of insurance.

41-2307. Term of credit life insurance and credit disability insurance.

41-2308. Provisions of policies and certificates of insurance — Disclosure to debtors.

41-2309. Filing, approval and withdrawal of forms.

41-2310. Premiums and refunds.

41-2311. Issuance of policies.

41-2312. Claims.

41-2313. Existing insurance — Choice of insurer.

41-2314. Enforcement.

41-2315. Judicial review. [Repealed.]

41-2316. Penalties.

§ 41-2301. Declaration of purpose. — The purpose of this chapter is to promote the public welfare by regulating credit life insurance and credit disability insurance. Nothing in this chapter is intended to prohibit or discharge or discourage reasonable competition. The provisions of this chapter shall be liberally construed.

History.

1961, ch. 330, § 536, p. 645.

§ 41-2302. Short title. — This chapter may be cited as “the model law for the regulation of credit life insurance and credit disability insurance”.

History.

1961, ch. 330, § 537, p. 645.

§ 41-2303. Scope of chapter. — All life insurance and all disability insurance in connection with loans or other credit transactions shall be subject to the provisions of this chapter; except, that insurance in connection with a loan or other credit transaction of more than fifteen (15) years duration shall not be subject to this chapter, nor shall insurance be subject to this chapter where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

History.

1961, ch. 330, § 538, p. 645; am. 1972, ch. 369, § 11, p. 1072; am. 1974, ch. 152, § 3, p. 1375; am. 1993, ch. 48, § 1, p. 125.

§ 41-2304. Definitions. — For the purposes of this chapter:

(1) “Credit life insurance” means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(2) “Credit disability insurance” means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

(3) “Creditor” means the lender of money or vendor of goods, services or property, including a lessor under a lease intended as a security, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender or vendor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them.

(4) “Debtor” means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

(5) “Indebtedness” means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

History.

1961, ch. 330, § 539, p. 645.

§ 41-2305. Forms of credit life insurance and credit disability insurance. — Credit life insurance and credit disability insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan.

(2) Individual policies of disability insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance.

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan.

(4) Group policies of disability insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies to provide such coverage.

History.

1961, ch. 330, § 540, p. 645.

§ 41-2306. Amount of insurance. — (1) Credit life insurance:

(a) The amount of credit life insurance shall not exceed the initial indebtedness, however the indebtedness may be repayable.

(b) In cases where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(c) Notwithstanding the provisions of (a) or (b) above, insurance on agricultural credit transactions not exceeding one year in duration may be written up to the amount of the loan commitment on a nondecreasing or level term plan.

(d) Except, that the amount of insurance provided under a group insurance contract shall be subject to section 41-2005(4)[, Idaho Code] (debtor groups).

(2) Credit disability insurance: The total amount of indemnity payable by credit disability insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

History.

1961, ch. 330, § 541, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in paragraph (1)(d) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2307. Term of credit life insurance and credit disability insurance. — The term of any credit life insurance or credit disability insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 41-2310[, Idaho Code].

History.

1961, ch. 330, § 542, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion at the end of the section was added by the compiler to conform to the statutory citation style.

CASE NOTES

Contract Formation.

Insurer was not required to extend credit life insurance coverage on the date the loan closed without first approving the application; thus, because the application's language made clear that it might not be approved and the insurer did not approve it, no contract was formed. *Shapley v. Centurion Life Ins. Co.*, 154 Idaho 875, 303 P.3d 234 (2013).

§ 41-2308. Provisions of policies and certificates of insurance — Disclosure to debtors. — (1) All credit life insurance and credit disability insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate shall be delivered to the debtor.

(2) Each individual policy or group certificate of credit life insurance, and/or credit disability insurance shall, in addition to other requirements of law, set forth the name and home office address of the insurer, and the identity by name or otherwise of the person or persons insured, the rate or amount of payment, if any, by the debtor separately for credit life insurance and credit disability insurance, a description of the amount, term and coverage including any exceptions, limitations and restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate. Contracts of credit group life insurance issued under this chapter shall comply with section 41-2005 (debtor groups), Idaho Code, except as permitted under rules and regulations of the director which gave due consideration to the reasonable requirements of credit life insurance issued on the group basis.

(3) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.

(4) If a debtor makes a separate payment for credit life or credit disability insurance and an individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance shall be delivered at such time to the debtor. The copy of the application for, or notice of proposed insurance, shall be signed by the debtor and shall set forth the identity by name or otherwise of the person or persons insured, the rate or amount of payment by the debtor, if any, separately for credit life insurance and credit disability insurance, and a statement that within thirty (30) days, if the insurance is accepted by the insurer, there will be delivered

to the debtor an individual policy or group certificate of insurance containing the name and home office address of the insurer, a description of the amount, term and coverage including any exceptions, limitations and restrictions. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. Such application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in [section 41-2307, Idaho Code](#).

History.

1961, ch. 330, § 543, p. 645; am. 1972, ch. 369, § 12, p. 1072.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Policy Delivery.

Insurer was not required to extend credit life insurance coverage on the date the loan closed without first approving the application; thus, no contract was formed absent approval, and the insurer was not required to deliver a policy. Because the premium payments were separate from the loan payments, the insurer fully complied with this section by providing the applicants with a copy of their insurance application and a notice of insurance underwriting practices. [Shapley v. Centurion Life Ins. Co., 154 Idaho 875, 303 P.3d 234 \(2013\)](#).

§ 41-2309. Filing, approval and withdrawal of forms. — (1) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this state and the schedule of premium rates pertaining thereto shall be filed with the director.

(2) The director shall within thirty (30) days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders, disapprove any such form if the premium rates charged or to be charged are excessive in relation to benefits, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any provision of this code or of any rule promulgated thereunder. In determining whether to disapprove any such forms the director shall give due consideration to past and prospective loss experience within and outside this state, to underwriting practice and judgment to the extent appropriate, and to all other relevant factors within and outside this state.

(3) If the director notifies the insurer that the form is disapproved, it is unlawful thereafter for such insurer to issue or use such form. In such notice, the director shall specify the reason for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued or used until the expiration of thirty (30) days after it has been so filed, unless the director shall give his prior written approval thereto.

(4) The director may, at any time after a hearing held after notice to the insurer in accordance with chapter 2, title 41, Idaho Code, withdraw his approval of any such form on any ground set forth in subsection (2) of this section. The written notice of such hearing shall state the reason for the proposed withdrawal.

(5) The insurer shall not issue such forms or use them after the effective date of such withdrawal.

(6) If a group policy of credit life insurance or credit disability insurance:
(a) has been delivered in this state before the effective date of this code, or
(b) has been or is delivered in another state before or after the effective date of this code, the insurer shall be required to file only the group certificate and notice of proposed insurance as specified in subsections (2) and (4) of [section 41-2308, Idaho Code](#), and such forms shall be approved by the director if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates on file with the director; provided, however, the premium rate in effect on existing group policies may be continued until the first policy anniversary date following the date this code becomes effective.

(7) Any order or final determination of the director under the provisions of this section shall be subject to judicial review as provided in chapter 2, title 41, Idaho Code.

History.

1961, ch. 330, § 544, p. 645; am. 2005, ch. 77, § 24, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrases "the effective date of this code" and "the date this code becomes effective" in subsection (6) refer to the effective date of S.L. 1961, Chapter 330, which was effective January 1, 1962.

§ 41-2310. Premiums and refunds. — (1) Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the director. No insurer shall issue any credit life insurance or credit disability insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the director.

(2) Each individual policy or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided, however, that the director shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the director.

(3) If a creditor requires a debtor to make any payment for credit life insurance or credit disability insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(4) The amount charged to a debtor for any credit life or credit disability insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(5) Nothing in this chapter shall be construed to authorize any payments for insurance now prohibited under any statute, or rule thereunder, governing credit transactions.

History.

1961, ch. 330, § 545, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2311. Issuance of policies. — All policies of credit life insurance and credit disability insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the director.

History.

1961, ch. 330, § 546, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2312. Claims. — (1) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(2) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

(3) No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

History.

1961, ch. 330, § 547, p. 645.

§ 41-2313. Existing insurance — Choice of insurer. — When credit life insurance or credit disability insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

History.

1961, ch. 330, § 548, p. 645.

§ 41-2314. Enforcement. — The director may, after notice and hearing, issue such rules and regulations as he deems appropriate for the supervision of this chapter. Whenever the director finds that there has been a violation of this chapter or any rules or regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the director, he shall set forth the details of his findings together with an order for compliance by a specified date. Such order shall be binding on the insurer and other person authorized or licensed by the director on the date specified unless sooner withdrawn by the director or a stay thereof has been ordered by a court of competent jurisdiction.

History.

1961, ch. 330, § 549, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2315. Judicial review. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 550, p. 645, was repealed by S.L. 2005, ch. 77, § 25.

§ 41-2316. Penalties. — In addition to any other penalty provided by law, any person who violates an order of the director after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the state of Idaho a sum not to exceed two hundred fifty dollars (\$250) which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed one thousand dollars (\$1,000). The director, in his discretion, may revoke or suspend the license or certificate of authority of the person guilty of such violation. Such order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review as provided in chapter 52, title 67, Idaho Code.

History.

1961, ch. 330, § 551, p. 645; am. 1977, ch. 142, § 8, p. 303; am. 2005, ch. 77, § 26, p. 258.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Chapter 24

PROPERTY INSURANCE CONTRACTS

Sec.

41-2401. Standard fire policy.

§ 41-2401. Standard fire policy. — (1) No fire insurer shall issue any fire insurance policy covering on property or interest therein in this state, other than on the form known as the New York standard as revised in 1943, except as follows:

(a) An insurer may print on or in its policy its name, location, date of incorporation, plan of operation, whether stock, mutual, reciprocal or organized under special charter provisions, and if mutual or reciprocal whether on cash premium or assessment plan; and if it be a stock company, the amount of its paid up capital stock, the names of its officers and agents, the number and date of the policy, and, if it is issued by an agent, the words, “this policy shall not be valid until countersigned by the duly authorized agent of the company at”; and, if a mutual or reciprocal insurer, the policy must state the contingent liability, if any, of its policyholders, members, or subscribers for payment of losses and expenses not provided for by its cash funds.

(b) An insurer may print or use in its policies printed forms of description and specifications of the property insured.

(c) An insurer insuring against damage by lightning may print in the clause enumerating the perils insured against the additional words, “also any damage by lightning whether fire ensues or not,” and in the clause providing for an apportionment of loss in case of other insurance the words, “whether by fire, lightning or both.”

(d) A domestic insurer may print in its policies any provisions which it is authorized or required by the law to insert therein, and any foreign insurer may, with the approval of the director, so print any provision required by its charter or deed of settlement, or by the laws of its own state or country, not contrary to the laws of this state; but the director shall require any provision which, in his opinion modifies the contract of insurance in such a way as to affect the question of loss, to be appended to the policy by an endorsement or rider as hereinafter provided.

(e) The blanks in the standard form may be completed in print or in writing.

(f) An insurer may print upon policies issued in compliance with the preceding provisions of this section the words, "Idaho standard policy."

(g) An insurer may write upon the margin or across the face of the policy, or write or print in type not smaller than nonpareil upon a slip, slips, rider or riders to be attached thereto, provisions adding to or relating to those contained in the standard form; and all such slips, riders, endorsements and provisions must be signed by the officers or agents of the insurer so using them.

(h) If the policy be made by a mutual, reciprocal or other insurer having special regulations lawfully applicable to its organization, membership, policies or contracts of insurance such regulations shall apply to and form a part of the policy as the same may be written or printed upon, attached or appended thereto.

(i) Every policy shall have legibly inscribed upon its face and filing back suitable words to designate whether the insurer making such insurance be a stock, mutual or reciprocal insurer, provided, that any insurer organized under special charter provisions may so indicate upon its policy and may add a statement of the plan under which it operates in this state.

(j) Every fire policy shall contain language that provides for a thirty (30) day written notice to the insured prior to cancellation of the policy, provided however, that where cancellation is for the nonpayment of premium, at least ten (10) days' notice of such cancellation, accompanied by the reason for the cancellation, shall be given. If delivered via United States mail, such ten (10) day notification period shall begin to run five (5) days following the date of postmark. Proof of mailing of notice of cancellation, or of intention not to renew, or of reasons for cancellation or nonrenewal to the named insured at his address shall be sufficient proof of notice.

(k) Every fire policy shall provide that it becomes effective at 12:01 a.m. of the standard time of the place where the property covered by the insurance is located, on the effective date of the policy.

(2) An insurer issuing the standard fire policy is authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction, nuclear radiation or radioactive

contamination, all whether directly or indirectly resulting from an insured peril under the policy; but nothing herein contained shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction, nuclear radiation or radioactive contamination.

(3) The standard fire policy is not mandatory for vehicle insurance, or for marine insurance, or inland marine insurance as the same is defined pursuant to [section 41-1401\(2\), Idaho Code](#), or for insurance on growing crops.

(4) Any policy or contract otherwise subject to the provisions of subsection (1) hereof, which includes either on an unspecified basis as to the coverage or for a single premium coverage against the peril of fire and substantial coverage against other perils need not comply with the provisions of subsection (1) hereof, provided:

(a) Such policy or contract shall afford coverage, with respect to the peril of fire, not less than the coverage afforded by such standard fire policy,

(b) The provisions in relation to mortgagee interests and obligations in such standard fire policy shall be incorporated therein without change,

(c) Such policy or contract is complete as to all of its terms without reference to the standard form of fire insurance policy or any other policy, and

(d) The director is satisfied that such policy or contract complies with the provisions hereof.

(5) With respect to a commercial insurance policy, such standard fire insurance policy may exclude coverage for loss by fire or other perils insured against if the fire or other perils are caused directly or indirectly by terrorism. As used in this section, the term “terrorism” means a violent act or an act that:

(a) Is dangerous to human life, property or infrastructure;

(b) Results in damage within the United States, or outside of the United States in the case of an air carrier or vessel or the premises of a United States mission; and

(c) Is committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States government by coercion.

History.

1961, ch. 330, § 552, p. 645; am. 1975, ch. 208, § 1, p. 577; am. 1978, ch. 91, § 1, p. 168; am. 1987, ch. 278, § 15, p. 571; am. 1990, ch. 240, § 3, p. 682; am. 2005, ch. 81, § 1, p. 292; am. 2005, ch. 237, § 1, p. 727; am. 2006, ch. 359, § 1, p. 1092; am. 2008, ch. 216, § 1, p. 672.

STATUTORY NOTES

Cross References.

County commissioners may insure county property, § 31-814.

Venue of actions against fire insurance companies, § 5-404.

Amendments.

This section was amended by two 2005 acts which appear to be compatible and have been compiled together.

The 2005 amendment, by ch. 81, added the second sentence in subsection (1)(j).

The 2005 amendment, by ch. 237, added subsection (5).

The 2006 amendment, by ch. 359, in subsection (1)(j), added the proviso at the end of the first sentence and added the second sentence.

The 2008 amendment, by ch. 216, in paragraph (5)(c), deleted “acting on behalf of any foreign person or foreign interest” following “individuals.”

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 19 of S.L. 1987, ch. 278 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

Effective Dates.

Section 2 of S.L. 1975, ch. 208 provided that the act should take effect on and after July 1, 1975.

Section 18 of S.L. 1987, ch. 278 read: “The provisions of this act shall take effect on July 1, 1987, provided however, that Section[s] 1 through 11 shall apply only to causes of action which accrue on and after July 1, 1987. Provided further, that [Section 6-1603, Idaho Code](#), as enacted herein, is hereby repealed and does sunset for causes of action which accrue after June 30, 1992.”

CASE NOTES

[Calculation of notice period.](#)

[Innocent insured.](#)

[Notice of cancellation.](#)

[Statute of limitations.](#)

[Time of instituting action.](#)

[Calculation of Notice Period.](#)

The phrase “twenty (20) day written notice to the insured”, as set forth in this section, requires actual notice before the 20-day period prior to cancellation runs and, accordingly, insured must actually receive written notice before the 20-day period commences. [Scanlon v. Empire Fire & Marine Ins. Co., 117 Idaho 691, 791 P.2d 737 \(Ct. App. 1990\)](#) (notice requirement later amended to 30 days).

[Innocent Insured.](#)

Where the husband was convicted of arson and insurance fraud after the insurer paid the loss, but the insurer sought to recover the loss payment, in the context of the New York standard fire policy as revised in 1943 (standard policy), the Idaho supreme court held that the language of the standard policy provided coverage for the innocent co-insured (the wife). [Trinity Universal Ins. Co. v. Kirsling, 139 Idaho 89, 73 P.3d 102 \(2003\)](#).

If an insured would have coverage under the New York standard fire policy as revised in 1943 (standard policy), as adopted in this section, but

does not have coverage under the language of the actual fire insurance policy issued, then the fire insurance policy issued provides less coverage than the standard policy and violates this section. Since the standard form does not specifically state that the act of any insured will be attributed to all insureds, the intent is that an innocent co-insured be able to recover for his or her proportionate share of the property. *Trinity Universal Ins. Co. v. Kirsling*, 139 Idaho 89, 73 P.3d 102 (2003).

Notice of Cancellation.

Generally speaking, provisions for notice of cancellation of insurance policies are intended to prevent cancellation of the policy without allowing insured ample opportunity to obtain other insurance. *Crowley v. Lafayette Life Ins. Co.*, 106 Idaho 818, 683 P.2d 854 (1984); *Scanlon v. Empire Fire & Marine Ins. Co.*, 117 Idaho 691, 791 P.2d 737 (Ct. App. 1990).

Statute of Limitations.

Statutory amendment by implication is disfavored and will not be inferred absent clear legislative intent; accordingly, the legislature, by providing in this section that no fire insurer shall issue fire insurance on a form other than the “New York Standard as Revised in 1943,” did not intend to amend the general five-year statute of limitations upon actions brought upon written contracts and did not create a one-year statute of limitations with respect to actions on policies of fire insurance. *Sunshine Mining Co. v. Allendale Mut. Ins. Co.*, 107 Idaho 25, 684 P.2d 1002 (1984).

Time of Instituting Action.

This section requires that fire insurers issue policies only on the New York standard form as revised in 1943; the form includes a clause specifying a 12-month limitation period for claims. However, § 5-216 establishes a five-year statute of limitation for contracts, including insurance policies, and § 29-110 prohibits any condition in a contract that would reduce that period; thus, the applicable limitations period for the commencement of a suit for reimbursement was five years. *Industrial Indem. Ins. Co. v. United States*, 749 F.2d 1390 (9th Cir. 1984).

Cited *Industrial Indem. Ins. Co. v. United States*, 757 F.2d 982 (9th Cir. 1985).

Construction.

Time of instituting action.

Construction.

Right of recovery on fire insurance policy could not be defeated by the insertion of a condition voiding it, if interest of insured be other than unconditional and sole ownership, where agent of insurer had knowledge that insured applied for a policy on his interest as mortgagee. *Carroll v. Hartford Fire Ins. Co.*, 28 Idaho 466, 154 P. 985 (1916).

Adoption by reference merely of the law of another state, as in the case of the reference herein to “New York standard” as now or may be hereafter constituted, was anomalous. *Carroll v. Hartford Fire Ins. Co.*, 28 Idaho 466, 154 P. 985 (1916).

Time of Instituting Action.

Failure to submit proof of loss within time specified in a standard fire insurance policy was not fatal to action on policy. *Southern Idaho Conference Assn. v. Hartford Fire Ins. Co.*, 31 Idaho 130, 169 P. 616 (1917).

RESEARCH REFERENCES

ALR. — Property damage insurance: What constitutes “contamination” within policy clause excluding coverage. 90 A.L.R.6th 635.

Chapter 25

CASUALTY INSURANCE CONTRACTS

Sec.

41-2501. Contracts are subject to general provisions.

41-2502. Uninsured motorist and underinsured motorist coverage for automobile insurance — Exceptions.

41-2503. Definitions and application.

41-2504. Application of uninsured motorist coverage.

41-2505. Subrogation rights of insurer.

41-2506. Cancellation of policies — Definitions.

41-2507. Cancellation of policies — Grounds.

41-2508. Notice of cancellation or intention not to renew.

41-2509. Cancellations and nonrenewal — Exceptions to.

41-2510. Exclusion and cancellation of designated individuals.

41-2511. Deductible — Permissive.

41-2512. Relieving liability for disclosure of cancellation and nonrenewal information.

41-2513. Workmen's [worker's] compensation policies — Segregation of participating and nonparticipating business.

41-2514. Medical payments limitation prohibited.

41-2515. Discount for certain age groups.

41-2516. Optional suspension of automobile insurance coverage.

41-2517. Short title.

41-2518. Definitions.

41-2519. Financial responsibility of transportation network companies and drivers — Proof of coverage.

41-2520. Disclosures.

41-2521. Automobile insurance.

§ 41-2501. Contracts are subject to general provisions. — All contracts of casualty insurance covering subjects of insurance resident, located, or to be performed in this state are subject to the applicable provisions of chapter 18[, title 41, Idaho Code] (the insurance contract), and to the other applicable provisions of this code.

History.

1961, ch. 330, § 553, p. 645.

STATUTORY NOTES

Cross References.

Transportation of children to and from school, liability insurance to be carried, § 33-1507.

Compiler's Notes.

The bracketed insertion was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

RESEARCH REFERENCES

ALR. — Insurable interest for liability insurance. [1 A.L.R.3d 1193](#).

Aircraft insurance: Risks and losses covered. [48 A.L.R.3d 1120](#).

Trailers as affecting automobile insurance. [65 A.L.R.3d 804](#).

“Vehicle” within meaning of insurance coverage or exception. [65 A.L.R.3d 824](#).

Scope of clause excluding from liability policy damage to property in care, custody, or control of insured. [8 A.L.R.4th 563](#).

Animal or livestock insurance: Risks and losses covered and excepted. [22 A.L.R.4th 1053](#); [47 A.L.R.4th 772](#).

Liability or indemnity policy on physician, surgeon, dentist and like. 33
A.L.R.4th 14; 14 A.L.R.5th 695.

Boiler and machinery insurance: Risks and losses covered. 49 A.L.R.4th
336.

What amounts to theft, robbery, or pilferage within a theft policy. 67
A.L.R.4th 82.

§ 41-2502. Uninsured motorist and underinsured motorist coverage for automobile insurance — Exceptions. — (1) Except as otherwise provided in subsection (2) of this section, no owner's or operator's policy of motor vehicle liability insurance that is subject to the requirements of section 49-1212(1) or (2), Idaho Code, shall be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless coverage is provided therein or supplemental thereto, in limits for bodily injury or death as set forth in [section 49-117, Idaho Code](#), as amended from time to time, under provisions approved by the director of the department of insurance, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured and underinsured motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom.

(2) A named insured shall have the right to reject either or both uninsured motorist coverage or underinsured motorist coverage, which rejection must be in writing or in an electronic record as authorized by the uniform electronic transactions act, chapter 50, title 28, Idaho Code, and such rejection shall be effective as to all other insureds and named insureds; and after which such rejected coverage need not be provided in or supplemental to a renewal or replacement policy issued by the same insurer or an affiliate of that insurer.

(3) Prior to the issuance of any new policy or the first renewal or replacement of any existing policy of motor vehicle liability insurance with an effective date on or after January 1, 2009, a named insured shall be provided a standard statement approved by the director of the department of insurance, explaining in summary form, both uninsured and underinsured motorist coverage, and the different forms of underinsured motorist coverage that might be available from insurers in Idaho.

(4) The provisions of this section shall not apply to policies of motor vehicle liability insurance for coverage on all-terrain vehicles, utility type vehicles, specialty off-highway vehicles or motorbikes as those terms are defined in [section 67-7101, Idaho Code](#).

History.

I.C., § 41-2502, as added by 1967, ch. 61, § 1, p. 124; am. 1988, ch. 265, § 572, p. 549; am. 2008, ch. 69, § 1, p. 183; am. 2009, ch. 157, § 1, p. 458.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 69, in the section catchline, inserted “and underinsured motorist”; designated the first sentence as subsection (1), and therein added the exception, substituted “No owner’s or operator’s policy of motor vehicle liability insurance that is subject to the requirements of section 49-1212(1) or (2), Idaho Code” for “No policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any natural person arising out of the ownership, maintenance or use of a motor vehicle,” and inserted “and underinsured” near the end; designated the last sentence as subsection (2), and therein rewrote the subsection, which formerly read: “The named insured shall have the right to reject such coverage, which rejection must be in writing; and provided further, such coverage need not be provided in or supplemental to a renewal policy where the named insured had rejected the coverage in connection with a policy previously issued to him by the same insurer”; and added subsection (3).

The 2009 amendment, by ch. 157, added “exceptions” in the section catchline; and added subsection (4).

Compiler’s Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 586 of S.L. 1988, ch. 265 provided that the act should become effective on and after January 1, 1989.

Section 3 of S.L. 2008, ch. 69 provided that the act should take effect on and after January 1, 2009.

Section 17 of S.L. 2009, ch. 157 declared an emergency. Approved April 9, 2009.

CASE NOTES

Application of coverage.

Coverage optional.

Estoppel.

Exclusionary language.

Exhaustion clauses.

Foreign no-fault statute.

Mandatory provisions.

Offer of coverage.

Physical contact.

Public policy.

Underinsured.

Application of Coverage.

Nothing in this section prohibits an exclusionary clause which removes from uninsured motorist coverage relatives who own a motor vehicle; nor does such an exclusion violate public policy. *Miller v. Farmers Ins. Co.*, 108 Idaho 896, 702 P.2d 1356 (1985).

The language of this section obviously contemplates that there is proof of the identity of the owner or operator of the vehicle; otherwise it could not be ascertained that the vehicle was uninsured. *Hammon v. Farmers Ins. Co.*, 109 Idaho 286, 707 P.2d 397 (1985).

Grant of summary judgment in favor of the insurer in the insureds' action to enforce an uninsured motor vehicle provision was proper where the other driver was identified and was not uninsured; further, the accident was not a hit and run. *Clark v. Prudential Prop. & Cas. Ins. Co.*, 138 Idaho 538, 66 P.3d 242 (2003).

Coverage Optional.

Unlike a motor vehicle liability policy, uninsured motorist coverage is not statutorily required as a condition of registration of or operation of a motor vehicle. *Dullenty v. Rocky Mt. Fire & Cas. Co.*, 111 Idaho 98, 721 P.2d 198 (1986), overruled on other grounds, *Colonial Penn Franklin Ins. Co. v. Welch*, 119 Idaho 913, 811 P.2d 838 (1991).

Estoppel.

Even though the contract was illegal for violating this section, justice and fairness required that the contract be enforced, and the insurer was estopped from denying coverage because of the illusion of coverage it has created. *Martinez v. Idaho Counties Reciprocal Mgt. Program*, 134 Idaho 247, 999 P.2d 902 (2000).

Exclusionary language.

A clause in the insurance contract removing the insured vehicle from the class of uninsured vehicles, even when the vehicle was driven by an uninsured motorist, did not contravene public policy or this section. *Locey v. Farmers Ins. Co.*, 115 Idaho 24, 764 P.2d 101 (Ct. App. 1988).

A non-owned vehicle exclusion in an insured's auto insurance policy violated public policy regarding limitations on underinsured motorist coverage, because, if the exclusion were to apply, the insured would have been better off to have been injured by an uninsured driver; the insured's uninsured motorist coverage would have provided her up to \$500,000 in coverage, while her underinsured motorist "coverage" would provide nothing. *Eastman v. Farmers Ins. Co.*, 164 Idaho 10, 423 P.3d 431 (2018).

Exhaustion Clauses.

Because the exhaustion clause in the insured's policy with the insurer violated public policy, it could not bar her recovery for uninsured motorists benefits. Under this section, claimants need not exhaust the limits of the tortfeasor's policy, but instead had to credit to the UIM insurer the gap between the settlement with the tortfeasor's insurer, if any, and the policy limits. *Hill v. Am. Family Mut. Ins. Co.*, 150 Idaho 619, 249 P.3d 812 (2011).

Foreign No-Fault Statute.

A foreign jurisdiction's no-fault statute does not render a foreign tortfeasor uninsured. *Ryals v. State Farm Mut. Auto. Ins. Co.*, 134 Idaho 302, 1 P.3d 803 (2000).

Mandatory Provisions.

While liability insurance is mandatory under § 49-233 (now § 49-1229), uninsured motorist coverage under this section is not; what is mandatory under this section is that the uninsured motorist coverage be offered at the time of purchase of liability insurance. *Miller v. Farmers Ins. Co.*, 108 Idaho 896, 702 P.2d 1356 (1985).

While liability insurance is mandatory, uninsured motorist coverage is not. What is mandatory under this section is that the uninsured motorist coverage be offered at the time of purchase of liability insurance. It is equally clear that this statutory scheme and its underlying public policy do not mandate underinsured coverage. *Featherston v. Allstate Ins. Co.*, 125 Idaho 840, 875 P.2d 937 (1994); *Martinez v. Idaho Counties Reciprocal Mgt. Program*, 134 Idaho 247, 999 P.2d 902 (2000).

Offer of Coverage.

Because uninsured/underinsured motorist coverage is not mandated in Idaho, and the policy automatically withheld uninsured/underinsured motorist coverage in every policy sold in states where it is not mandated, uninsured/underinsured motorist coverage would never be provided in Idaho and was never offered to the city when it purchased the policy; therefore, the policy was issued in violation of this section. *Martinez v. Idaho Counties Reciprocal Mgt. Program*, 134 Idaho 247, 999 P.2d 902 (2000).

Physical Contact.

Hit-and-run coverage is neither mandated nor prohibited under the Idaho uninsured motorist statute; therefore, the physical contact requirement becomes a matter of contract between the insured and the insurer which the court will not disturb. *Hammon v. Farmers Ins. Co.*, 109 Idaho 286, 707 P.2d 397 (1985).

A physical contact requirement may be inserted into an uninsured motorist endorsement. *Miller v. United States Fid. & Guar. Ins. Co.*, 112 Idaho 955, 738 P.2d 425 (Ct. App. 1987).

Insured was not “hit” or “struck” by a motor vehicle within the meaning of the uninsured motorist coverage of his insurance policy that covered any uninsured vehicle that “hits” the insured, where the unidentified truck passed him at high speed, blowing dust and debris, his horse became frightened, and it reared and fell on the insured. *Miller v. United States Fid. & Guar. Ins. Co.*, 112 Idaho 955, 738 P.2d 425 (Ct. App. 1987).

Summary judgment was proper where the insurance policy provided that in the event of a hit-and-run accident, the identity of the operator and the owner of the hit-and-run vehicle may be unknown, but that there must be physical contact, and here, there was no physical contact, even though the only alternative would have been a head-on collision. *Stamper v. Allstate Ins. Co.*, 115 Idaho 237, 766 P.2d 707 (1988).

Public Policy.

Enforcing exclusions, which provide coverage if an insured is injured by an uninsured driver, but not if injured by an underinsured motorist while riding in a non-owned vehicle, would allow insurance companies to eviscerate the purpose of such coverage. Such results plainly violate public policy. *Eastman v. Farmers Ins. Co.*, 164 Idaho 10, 423 P.3d 431 (2018).

The legislative history and text of this section demonstrate that the legislature knew that insurers would offer different kinds of underinsured motorist (UIM) coverage, decided not to require insurers to offer only excess-type UIM coverage, and chose to allow the use of offset-type UIM coverage. *Wood v. Farmers Ins. Co.*, — Idaho —, 454 P.3d 1126 (2019).

Underinsured.

An “uninsured motor vehicle,” within the meaning of this section, does not encompass vehicles that are “underinsured,” i.e., where the coverage is inadequate to compensate for the damages suffered by the injured party, even where such a construction results in the injured person receiving less compensation when injured by an insured vehicle than by an uninsured vehicle. *Blackburn v. State Farm Mut. Auto. Ins. Co.*, 108 Idaho 85, 697 P.2d 425 (1985).

“Other owned vehicle” exclusion in insurance policy that provided underinsured motorist coverage only when occupying a vehicle insured under the policy does not contravene a public policy of protecting innocent

victims of negligent and financially irresponsible motorists. [Meckert v. Transamerica Ins. Co.](#), 108 Idaho 597, 701 P.2d 217 (1985).

Language in exclusion to underinsured motorist coverage to the effect that no underinsured motorist coverage was afforded if the covered person was injured while occupying a motor vehicle not insured under the policy was unambiguous and did not conflict with Idaho statutes. [Meckert v. Transamerica Ins. Co.](#), 108 Idaho 597, 701 P.2d 217 (1985).

A physical contact requirement may be inserted into an uninsured motorist endorsement. [Miller v. United States Fid. & Guar. Ins. Co.](#), 112 Idaho 955, 738 P.2d 425 (Ct. App. 1987).

Summary judgment was properly granted for an insurer in an underinsured motorist coverage dispute because there was no mandatory coverage for such in Idaho. [Andrae v. Idaho Counties Risk Mgmt. Program Underwriters](#), 145 Idaho 33, 175 P.3d 195 (2007).

Cited [Linn v. North Idaho Dist. Medical Serv. Bureau, Inc.](#), 102 Idaho 679, 638 P.2d 876 (1981); [Vincent v. Safeco Ins. Co. of Am.](#), 136 Idaho 107, 29 P.3d 943 (2001).

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

ALR. — Uninsured motorist indorsement: construction and application of requirement that there be “physical contact” with unidentified or hit-and-run vehicle; “miss-and-run” cases. [77 A.L.R.5th 319](#).

Uninsured motorist indorsement: general issues regarding requirement that there be “physical contact” with unidentified or hit-and-run vehicle. [78 A.L.R.5th 341](#).

Uninsured motorist indorsement: construction and application of requirement that there be “physical contact” with unidentified or hit-and-run vehicle; “hit-and-run” cases. [79 A.L.R.5th 289](#).

Validity, construction, and application of exhaustion clause of underinsured motorist coverage plan. [75 A.L.R.6th 235](#).

Application of uninsured or underinsured motorist or no-fault insurance to school bus incidents. 80 A.L.R.6th 389.

§ 41-2503. Definitions and application. — (1) For the purposes of uninsured motorist coverage, the term “uninsured motor vehicle” shall, subject to the terms and conditions of such coverage, be deemed to include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified therein because of insolvency.

(2) For purposes of underinsured motorist coverage, subject to the further definitions, terms and conditions of such coverage, the term “underinsured motor vehicle” means a motor vehicle that is a self-insured motor vehicle, or a motor vehicle that is covered by a policy of motor vehicle liability insurance or an indemnity bond, with limits for bodily injury or death at least equal to those limits set forth in [section 49-117, Idaho Code](#).

(3) Except as provided in subsections (1) and (2) of this section, the terms and conditions of any policy of motor vehicle liability insurance providing uninsured motorist coverage or underinsured motorist coverage are not altered or amended.

History.

[I.C., § 41-2503](#), as added by 1967, ch. 61, § 2, p. 124; am. 2008, ch. 69, § 2, p. 184.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 69, rewrote the section catchline, which formerly read: “‘Uninsured motor vehicle’ defined”; designated the formerly undesignated section as subsection (1), and therein substituted “uninsured motorist coverage” for “this coverage”; and added subsections (2) and (3).

Effective Dates.

Section 3 of S.L. 2008, ch. 69 provided that the act should take effect on and after January 1, 2009.

CASE NOTES

Cited Blackburn v. State Farm Mut. Auto. Ins. Co., 108 Idaho 85, 697 P.2d 425 (1985).

§ 41-2504. Application of uninsured motorist coverage. — An insurer's insolvency protection shall be applicable only to accidents occurring during a policy period in which its insured's uninsured motorist coverage is in effect where the liability insurer of the tortfeasor becomes insolvent within one (1) year after such an accident. Nothing herein contained shall be construed to prevent any insurer from affording insolvency protection under terms and conditions more favorable to its insureds than is provided hereunder.

History.

I.C., § 41-2504, as added by 1967, ch. 61, § 3, p. 124.

CASE NOTES

Cited *Blackburn v. State Farm Mut. Auto. Ins. Co.*, 108 Idaho 85, 697 P.2d 425 (1985).

§ 41-2505. Subrogation rights of insurer. — In the event of payment to an insured under the coverage required by this section and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such insured against any person or organization legally responsible for the bodily injury for which such payment is made, including the proceeds recoverable from the assets of the insolvent insurer. Whenever an insurer shall make payment under the coverage required by this section and which payment is occasioned by an insolvency, such insurer's right of recovery or reimbursement shall not include any rights against the insured of said insolvent insurer, but such paying insurer shall have the right to proceed directly against the insolvent insurer or its receiver, and in pursuance of such right such paying insurer shall possess any rights which the insured of the insolvent company might otherwise have had, if the insured of the insolvent insurer had personally made the payment.

History.

I.C., § 41-2505, as added by 1967, ch. 61, § 4, p. 124.

CASE NOTES

Cited Carlson v. Stanger, 146 Idaho 642, 200 P.3d 1191 (Ct. App. 2008).

RESEARCH REFERENCES

ALR. — Conduct or inaction by insurer constituting waiver of, or creating estoppel to assert, right of subrogation. 125 A.L.R.5th 1.

§ 41-2506. Cancellation of policies — Definitions. — (1) As used in sections 41-2506 through 41-2512[, Idaho Code,] of this act:

(a) “Policy” means any one or more of the following portions of an automobile insurance policy, delivered or issued for delivery in this state, insuring a natural person as named insured, or one or more related individuals resident of the same household, and under which the insured vehicles therein designated are motor vehicles of the private passenger or station wagon type (not used for public or livery conveyance of passengers, or rented to others) or any other four-wheel motor vehicles with a load capacity of 15,000 pounds or less not used in the occupation, profession, or business of the insured and, (i) Insuring against bodily injury and property damage liability; (ii) Insuring against physical damage;

(iii) Insuring against risks commonly included under “comprehensive coverage”; (iv) Relating to medical payments;

(v) Providing uninsured motorist coverage.

(b) Policy does not mean automobile liability insurance: (i) Issued under an assigned risk plan; or (ii) Insuring more than four (4) motor vehicles; or (iii) Covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(c) “Renewal” or “to renew” means the issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term. Any policy with a policy period or term of less than six (6) months or any policy with no fixed expiration date shall for the purpose of this section be considered as if written for successive policy periods or terms of six (6) months.

(d) “Nonpayment of premium” means failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums on a policy or any installment of such premium,

whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

(2) Sections 41-2506 through 41-2512[, Idaho Code,] of this act shall not apply to any policy which has been in effect less than sixty (60) days at the time notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy.

History.

I.C., § 41-2506, as added by 1969, ch. 214, § 59, p. 625.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in the introductory paragraph in subsection (1) and in subsection (2) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2507. Cancellation of policies — Grounds. — No notice of cancellation of a policy shall be effective and the insurer shall not refuse renewal of a policy, unless based on one (1) or more of the following reasons:

- (1) Nonpayment of premium; or
- (2) The policy was obtained through a material misrepresentation; or
- (3) Any insured violated any of the terms and conditions of the policy; or
- (4) The named insured failed to disclose fully his motor vehicle accidents and moving traffic violations, or his losses covered under any automobile physical damage or comprehensive coverage, for the preceding thirty-six (36) months if called for in the application; or
- (5) As to renewal of the policy, if the insured at any time while the policy was in force failed to disclose fully to the insurer, upon request therefor, facts relative to accidents and losses incurred material to underwriting of the risk; or
- (6) Any insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim; or
- (7) The named insured or any other operator who either resides in the same household or customarily operates an automobile insured under such policy:
 - (a) Has, within the thirty-six (36) months prior to the notice of cancellation or nonrenewal, had his driver's license under suspension or revocation; or
 - (b) Has a history of and is subject to epilepsy or heart attacks and such individual cannot produce a certificate from a physician testifying to his unqualified ability to operate a motor vehicle safely; or
 - (c) Has an accident record, conviction record, either criminal or traffic, physical, mental or other condition which is such that his operation of an automobile might endanger the public safety; or

(d) Has, while the policy is in force, engaged in a prearranged competitive speed contest while operating or riding in an automobile insured under the policy; or

(e) Has, within the thirty-six (36) months prior to the notice of cancellation or nonrenewal, been addicted to the use of narcotics or other drugs; or

(f) Uses alcoholic beverages to excess; or

(g) Has been convicted, or forfeited bail, during the thirty-six (36) months immediately preceding the notice of cancellation or nonrenewal; for

(i) Any felony; or

(ii) Criminal negligence resulting in death, homicide or assault arising out of the operation of a motor vehicle; or

(iii) Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs; or

(iv) Leaving the scene of an accident without stopping to report; or

(v) Theft or unlawful taking of a motor vehicle; or

(vi) Making fraudulent statements in an application for a driver's license; or

(h) Has been convicted of, has had a judgment entered against, or forfeited bail for, three (3) or more violations within the thirty-six (36) months immediately preceding the notice of cancellation or nonrenewal of any law, ordinance or regulation of any state for which a violation point is assessed by the Idaho transportation department under the provisions of [section 49-326, Idaho Code](#), whether or not the violations were repetitions of the same offense or different offenses; or

(8) The insured automobile is:

(a) So mechanically defective that its operation might endanger public safety; or

(b) Used in carrying passengers for hire or compensation, except that the use of an automobile for a carpool shall not be considered use of an

automobile for hire or compensation; or

(c) Used in the business of transportation of flammables or explosives; or

(d) An authorized emergency vehicle; or

(e) Modified or changed in condition during the policy period so as to increase the risk substantially; or

(f) Subject to an inspection law and has not been inspected or, if inspected, has failed to qualify; or

(9) As to the renewal of the policy only, the insured automobile is registered in a jurisdiction other than Idaho.

History.

I.C., § 41-2507, as added by 1969, ch. 214, § 60, p. 625; am. 1992, ch. 250, § 1, p. 734; am. 2013, ch. 56, § 1, p. 130.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 56, added subsection (9).

§ 41-2508. Notice of cancellation or intention not to renew. — (1) No cancellation of a policy to which section 41-2506[, Idaho Code,] of this act applies shall be effective unless notice thereof is mailed or delivered by the insurer to the named insured at least twenty (20) days prior to the effective date of cancellation, except that where cancellation is for nonpayment of premium at least ten (10) days' notice of cancellation accompanied by the reason therefor shall be given. Unless the reason or reasons accompany or are included in the notice, the notice shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than ten (10) days prior to the effective date of cancellation, the insurer will specify the reason or reasons for such cancellation.

(2) No insurer shall fail to renew a policy to which section 41-2506[, Idaho Code,] of this act applies unless it shall mail or deliver to the named insured, at the address shown on the policy, at least thirty (30) days' advance notice of its intention not to renew. Unless the reason or reasons accompany or are included in the notice, the notice shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than fifteen (15) days prior to the effective date or nonrenewal, the insurer will specify the reason or reasons for such nonrenewal. This subsection shall not apply in case of nonpayment of premium, or if the insurer has manifested its willingness to renew. Notwithstanding the failure of an insurer to comply with this subsection, the policy shall terminate on the effective date of any other policy procured by the insured, with respect to any automobile designated in both policies. Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation or nonrenewal which existed before the effective date of the renewal.

(3) Proof of mailing of notice of cancellation, or of intention not to renew or of reasons for cancellation or nonrenewal to the named insured at his address last of record with the insurer, shall be sufficient proof of notice.

(4) When a policy is canceled, other than for nonpayment of premium, or in the event of failure to renew a policy to which subsection (2), above,

applies, the insurer shall notify the named insured of any possible eligibility for insurance through an automobile assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew, and shall state that such notice of availability of the automobile assigned risk plan is given pursuant to this section.

History.

I.C., § 41-2508, as added by 1969, ch. 214, § 61, p. 625.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions near the beginning of subsections (1) and (2) were added by the compiler to conform to the statutory citation style.

CASE NOTES

Subsection (3) Exclusions.

Because subsection (3) of this section did not apply to credit union/lienholder, as credit union was not the named insured in the policy and credit union was, therefore, entitled to actual notice of cancellation of automobile insurance policy before termination of the endorsement and did not receive actual notice, credit union was entitled to summary judgment in its favor for payment of the remaining amount due on the loan. *Pocatello R.R. Fed. Credit Union v. Dairyland Ins. Co.*, 129 Idaho 444, 926 P.2d 628 (1996).

§ 41-2509. Cancellations and nonrenewal — Exceptions to. — Nothing contained in sections 41-2506 through 41-2512[, Idaho Code,] of this act shall be construed to prevent the cancellation or nonrenewal of any such insurance where:

(1) Cancellation or nonrenewal is ordered under or in connection with a statutory delinquency proceeding commenced against the insurer under chapter 33[, title 41] (rehabilitations and liquidations), Idaho Code, or

(2) Cancellation or nonrenewal has been consented to by the director on a showing that continuation of such insurance can reasonably be expected to create a condition in the insurer hazardous to its policyholders, or to its creditors, or to its members, subscribers, or stockholders, or to the public.

History.

I.C., § 41-2509, as added by 1969, ch. 214, § 62, p. 625.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in the introductory paragraph and in subsection (1) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2510. Exclusion and cancellation of designated individuals. — Except as respects the legal liability of the named insured, the insurer shall have the right to exclude, cancel or refuse to renew coverage under an automobile insurance policy as to designated individuals. Any such cancellation or refusal to renew shall be acknowledged by the signature of the named insured, and shall be subject to the applicable provisions of sections 41-2506 through 41-2512[, Idaho Code,] of this act as for cancellation or refusal to renew the policy.

History.

I.C., § 41-2510, as added by 1969, ch. 214, § 63, p. 625.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of the section was added by the compiler to conform to the statutory citation style.

§ 41-2511. Deductible — Permissive. — Nothing in sections 41-2506 through 41-2512, Idaho Code, shall prohibit, or be construed to prohibit, an insurer from requiring a provision for a reasonable deductible not exceeding two hundred fifty dollars (\$250) in amount as to comprehensive coverage and not exceeding five hundred dollars (\$500) in amount as to collision or physical damage coverages of the policy, as a condition to renewal of an automobile insurance policy.

History.

I.C., § 41-2511, as added by 1969, ch. 214, § 64, p. 625; am. 1991, ch. 312, § 1, p. 819; am. 2012, ch. 90, § 1, p. 253.

STATUTORY NOTES

Amendments.

The 2012 amendment, by ch. 90, substituted “two hundred fifty dollars (\$250) in amount as to comprehensive coverage and not exceeding five hundred dollars (\$500)” for “one hundred fifty dollars (\$150) in amount as to comprehensive coverage and not exceeding three hundred dollars (\$300)”.

§ 41-2512. Relieving liability for disclosure of cancellation and nonrenewal information. — There shall be no liability on the part of and no cause of action of any nature shall arise against the director, or the insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or refusal to renew any policy under sections 41-2506 through 41-2512[, Idaho Code,] of this act, for any statement made by any of them in any written notice or explanation of cancellation or refusal to renew, for the providing of information pertaining thereto, or for statements made or evidence submitted at the hearings conducted in connection therewith.

History.

I.C., § 41-2512, as added by 1969, ch. 214, § 65, p. 625.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the middle of the section was added by the compiler to conform to the statutory citation style.

§ 41-2513. Workmen's [worker's] compensation policies — Segregation of participating and nonparticipating business. — (1) With respect to workmen's [worker's] compensation insurance delivered or issued for delivery in this state, the insurer shall not pay dividends to the holders of participating insurance contracts out of profits or gains realized from nonparticipating contracts.

(2) An insurer issuing both participating and nonparticipating workmen's [worker's] compensation policies shall maintain a system of accounting which segregates the participating from the nonparticipating business and clearly shows the profits and losses upon each category of business.

History.

I.C., § 41-2513, as added by 1969, ch. 214, § 66, p. 625.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in the section heading and in both paragraphs in the text were added by the compiler to reflect the current provisions of Title 72, Idaho Code.

§ 41-2514. Medical payments limitation prohibited. — Recovery of costs incurred for injuries sustained under an automobile medical payments insurance contract shall not be limited to less than three (3) years from the date of the injury. This section shall not pertain to any injury that is not discovered and treated within one year from the date of the occurrence that caused the injury.

History.

I.C., § 41-2514, as added by 1976, ch. 102, § 1, p. 425.

§ 41-2515. Discount for certain age groups. — (1) Any insurer offering for sale an automobile insurance policy, as policy is defined in subsection (a) of [section 41-2506, Idaho Code](#), in which there is insured a principal operator who is fifty-five (55) years of age or older, shall provide for an appropriate reduction in premium charges for liability, medical payments and collision coverages if the principal operator fifty-five (55) years of age or older has successfully completed a motor vehicle accident prevention course which meets criteria established by the transportation department. Any discount used by an insurer shall be presumed appropriate unless credible evidence data demonstrates otherwise.

(2) Upon successful completion of an approved motor vehicle accident prevention course, each participant shall be issued, by the course's sponsoring entity, a certificate of completion which shall be the basis of the qualification for the discount on the automobile insurance.

(3) The premium reduction required in this section shall be effective for an insured for a three (3) year period after successful completion of the approved course, except that the insurer may require, as a condition of providing and maintaining the discount, that the insured for a three (3) year period after course completion, not be involved in an accident for which the insured is at fault or be found guilty of a moving traffic violation.

(4) The provisions of this section shall not apply in the event the approved course is specified by a court or other governmental entity resulting from a moving traffic violation.

(5) Each participant shall take an approved course every three (3) years to continue to be eligible for the reduction in premiums.

(6) Nothing in the provisions of this section shall be deemed to prohibit an insurer from canceling or not renewing an automobile insurance policy for grounds enumerated in [section 41-2507, Idaho Code](#), or in chapter 25, title 41, Idaho Code.

(7) The provisions of this section shall not apply in the event that such an insurer offers a premium reduction which is substantially comparable to the premium reduction required in this section and in no event shall such

insurer be required to provide both comparable premium reductions on a cumulative basis.

History.

I.C., § 41-2515, as added by 1989, ch. 152, § 1, p. 362; am. 2002, ch. 368, § 1, p. 1036; am. 2006, ch. 30, § 1, p. 93.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 30, substituted “fifty-five (55)” for “sixty-five (65)” twice in subsection (1).

§ 41-2516. Optional suspension of automobile insurance coverage. —

(1) If a person enters into a contract with an insurer for coverage under an automobile insurance policy as defined in [section 41-2506, Idaho Code](#), the insurer may allow the person to suspend policy coverages. The suspension period may begin at any time, at the person's option. All requests for suspension of coverage shall be confirmed in writing by the insurer to the insured regardless of the method used by the insured to request suspension of coverage. The suspension of coverage shall not constitute a cancellation of the policy. For those coverages suspended, during the period of suspension, premiums shall not be charged to the person, and the insurer shall not be liable for any loss under such suspended coverages occurring during said suspension period. The period of suspension may be changed at any time upon written agreement by the parties. This shall not preclude the insurer's right to reinspect the previously insured motor vehicle regarding its insurability.

(2) Suspended premium may accrue on a pro rata basis as a credit for future premium.

(3) If a person drives a motor vehicle within the state of Idaho while the liability coverage of the policy is suspended, he shall be subject to the penalties set out for the violation of the provisions of [section 49-1428, Idaho Code](#).

(4) The provisions of this section shall apply to a policy entered into or renewed after July 1, 1990.

History.

[I.C., § 41-2516](#), as added by 1990, ch. 57, § 1, p. 133; am. 1991, ch. 273, § 1, p. 710.

§ 41-2517. Short title. — Sections 41-2517 through 41-2521, Idaho Code, shall be known and may be cited as the “Idaho Transportation Network Insurance Act.”

History.

I.C., § 41-2517, as added by 2015, ch. 316, § 1, p. 1232.

§ 41-2518. Definitions. — As used in this act:

(1) “Digital network” means any online enabled application, software, website or system offered or utilized by a transportation network company that enables the prearrangement of rides with transportation network company drivers.

(2) “Driver” or “transportation network company driver” means an individual who:

(a) Receives connections to potential passengers and related services from a transportation network company in exchange for payment of a fee to the transportation network company; and

(b) Uses a personal vehicle to provide services for riders matched through a digital network controlled by a transportation network company in return for compensation or payment of a fee.

(3) “Personal vehicle” means a vehicle that is used by a transportation network company driver in connection with providing a prearranged ride and is:

(a) Owned, leased or otherwise authorized for use by the transportation network company driver; and

(b) Not a taxicab, limousine or for-hire vehicle.

(4) “Prearranged ride” means the provision of transportation by a driver to a rider, beginning when a driver accepts a ride requested by a rider through a digital network controlled by a transportation network company, continuing while the driver transports a requesting rider and ending when the last requesting rider departs from the personal vehicle. A prearranged ride does not include transportation provided using a taxi, limousine or other for-hire vehicle.

(5) “Rider” or “transportation network company rider” means an individual or persons who use a transportation network company’s digital network to connect with a transportation network driver who provides prearranged rides to the rider in the driver’s personal vehicle between points chosen by the rider.

(6) “Transportation network company” means a corporation, partnership, sole proprietorship or other entity that is operating in Idaho that uses a digital network to connect transportation network company riders to transportation network company drivers who provide prearranged rides. A transportation network company shall not be deemed to control, direct or manage the personal vehicles or transportation network company drivers that connect to its digital network, except where agreed to by written contract.

History.

I.C., § 41-2518, as added by 2015, ch. 316, § 1, p. 1232.

STATUTORY NOTES

Compiler’s Notes.

The term “this act” in the introductory paragraph refers to S.L. 2015, chapter 316, which is codified as §§ 41-2517 through 41-2521 and 49-3703.

§ 41-2519. Financial responsibility of transportation network companies and drivers — Proof of coverage. — (1) Effective July 1, 2015, and thereafter, a transportation network company driver or transportation network company on the driver's behalf shall maintain primary automobile insurance that recognizes that the driver is a transportation network company driver or otherwise uses a vehicle to transport passengers for compensation and covers the driver:

(a) While the driver is logged on to the transportation network company's digital network; or

(b) While the driver is engaged in a prearranged ride.

(2) The following automobile insurance requirements shall apply while a participating transportation network company driver is logged on to the transportation network company's digital network and is available to receive transportation requests but is not engaged in a prearranged ride:

(a) Primary automobile liability insurance in the amount of at least fifty thousand dollars (\$50,000) for death and bodily injury per person, one hundred thousand dollars (\$100,000) for death and bodily injury per incident and twenty-five thousand dollars (\$25,000) for property damage.

(b) The coverage requirements of this subsection may be satisfied by any of the following:

(i) Automobile insurance maintained by the transportation network company driver;

(ii) Automobile insurance maintained by the transportation network company; or

(iii) Any combination of the two (2).

(3) The following automobile insurance requirements shall apply while a transportation network company driver is engaged in a prearranged ride:

(a) Primary automobile liability insurance that provides at least one million dollars (\$1,000,000) for death, bodily injury and property damage;

(b) The coverage requirements of this subsection may be satisfied by any of the following:

- (i) Automobile insurance maintained by the transportation network company driver;
- (ii) Automobile insurance maintained by the transportation network company; or
- (iii) Any combination of the two (2).

(4) If insurance maintained by a driver in subsection (2) or (3) of this section has lapsed or does not provide the required coverage, insurance maintained by a transportation network company shall provide the coverage required by this section beginning with the first dollar of a claim and have the duty to defend such claim.

(5) Coverage under an automobile insurance policy maintained by the transportation network company shall not be dependent on a personal automobile insurer first denying a claim nor shall a personal automobile insurance policy be required to first deny a claim.

(6) Insurance required by this section may be placed with an insurer authorized under title 41, Idaho Code, or with a surplus lines insurer eligible under the surplus line law, [sections 41-1211 through 41-1234, Idaho Code](#).

(7) Insurance satisfying the requirements of this section shall be deemed to satisfy the financial responsibility requirement for a motor vehicle under chapter 12, title 49, Idaho Code.

(8) A transportation network company driver shall carry proof of coverage satisfying subsections (2) and (3) of this section with him or her at all times during his or her use of a vehicle in connection with a transportation network company's digital network. In the event of an accident, a transportation network company driver shall provide this insurance coverage information to the directly interested parties, automobile insurers and investigating police officers, upon request. Upon such request, a transportation network company driver shall also disclose to directly interested parties, automobile insurers, and investigating police officers whether he or she was logged on to the transportation network company's digital network or on a prearranged ride at the time of an accident.

History.

I.C., § 41-2519, as added by 2015, ch. 316, § 1, p. 1232.

§ 41-2520. Disclosures. — The transportation network company shall disclose in writing to transportation network company drivers the following before they are allowed to accept a request for a prearranged ride on the transportation network company's digital network:

(1) The insurance coverage, including the types of coverage and the limits for each coverage, that the transportation network company provides while the transportation network company driver uses a personal vehicle in connection with a transportation network company's digital network; and

(2) That the transportation network company driver's own automobile insurance policy might not provide any coverage while the driver is logged on to the transportation network company's digital network and is available to receive transportation requests or is engaged in a prearranged ride depending on its terms.

History.

I.C., § 41-2520, as added by 2015, ch. 316, § 1, p. 1232.

§ 41-2521. Automobile insurance. — (1) Insurers that write automobile insurance in this state may exclude or continue to exclude any and all coverage afforded under the owner's insurance policy for any loss or injury that occurs while a driver is logged on to a transportation network company's digital network or while a driver provides a prearranged ride. This right to exclude all coverage may apply to any coverage included in an automobile insurance policy including, but not limited to:

- (a) Liability coverage for bodily injury and property damage;
- (b) Personal injury protection coverage;
- (c) Uninsured and underinsured motorist coverage;
- (d) Medical payments coverage;
- (e) Comprehensive physical damage coverage; and
- (f) Collision physical damage coverage.

Such exclusions shall apply notwithstanding any requirement under chapter 12, title 49, Idaho Code. Nothing in this section implies or requires that a personal automobile insurance policy provide coverage while the driver is logged on to the transportation network company's digital network, while the driver is engaged in a prearranged ride or while the driver otherwise uses a vehicle to transport passengers for compensation. Nothing shall be deemed to preclude an insurer from providing coverage for the transportation network company driver's vehicle, if it so chose to do so by contract or endorsement.

(2) Automobile insurers that exclude the coverage described in [section 41-2519, Idaho Code](#), shall have no duty to defend or indemnify any claim expressly excluded thereunder. Nothing in this act shall be deemed to invalidate or limit an exclusion contained in a policy, including any policy sold or approved for sale in Idaho prior to the enactment of this act. An automobile insurer that defends or indemnifies a claim against a driver that is excluded under the terms of its policy shall have a right of contribution against other insurers that provide automobile insurance to the same driver in satisfaction of the coverage requirements of [section 41-2519, Idaho Code](#), at the time of loss.

(3) In a claims coverage investigation, transportation network companies and any insurer potentially providing coverage under [section 41-2519, Idaho Code](#), shall cooperate to facilitate the exchange of relevant

information with directly involved parties and any insurer of the transportation network company driver, if applicable, including the precise times that a transportation network company driver logged on and off of the transportation network company's digital network in the twelve (12) hour period immediately preceding and in the twelve (12) hour period immediately following the accident and disclose to one another a clear description of the coverage, exclusions and limits provided under any automobile insurance maintained under [section 41-2519, Idaho Code](#).

History.

[I.C., § 41-2521](#), as added by 2015, ch. 316, § 1, p. 1232.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in the second sentence in subsection (2) refers to S.L. 2015, chapter 316, which is codified as §§ 41-2517 through 41-2521 and 49-3703. Chapter 316 of S.L. 2015 became effective on July 1, 2015.

Chapter 26

SURETY INSURANCE CONTRACTS

Sec.

41-2601, 41-2602. Director's certificate as to authorized surety insurers, withdrawing insurers. [Repealed.]

41-2603. Justification of surety — Director's certificate as evidence.

41-2604. May be sole surety on bonds.

41-2605. Certificate as evidence of authority to be sole surety.

41-2606. Premiums on bonds — Allowance as expense costs — Limit as to amount.

41-2607. Bond premiums as part of costs in actions and proceedings.

41-2608. Deposit for protection of surety.

41-2609. Release of surety on certain official bonds.

41-2610. Estoppel to deny corporate power.

41-2611. Deduction of bond premium from wages of employees.

41-2612. Release of surety on bond of licensee or permittee.

41-2613. Surety companies authorized to become surety under arrest bond certificate — Certificate as cash bail.

§ 41-2601, 41-2602. Director's certificate as to authorized surety insurers, withdrawing insurers. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised (S.L. 1961, ch. 330, §§ 554 and 555) were repealed by S.L. 1982, ch. 334, § 1.

§ 41-2603. Justification of surety — Director's certificate as evidence.

— (1) The director is authorized to issue to any person applying therefor, a certificate showing that any surety insurer that has complied with the laws of the state of Idaho is qualified to do a surety business in this state, and stating the general terms of the risks authorized to be so written.

(2) Any such certificate or any certified copy of any uncanceled certificate, shall be received in evidence as a sufficient justification of such surety and its authority to do business in this state: provided, however, that the certificate of the county recorder to any such certified copy, or any certificate furnished directly by the director to an applicant therefor, must bear a date the same as, or later than the date of the bond, undertaking or obligation upon which justification is being made.

History.

1961, ch. 330, § 556, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Justification.

Surety companies.

Justification.

Former law regarding justification of sureties contemplated that surety company may be called upon to justify, just the same as any other surety, and prescribed method of justification. Where exceptions have been taken to surety company, as surety upon undertaking on appeal, then such company had to comply with statutory requirements by giving notice that it would justify, and by justifying. Method of justifying was by presenting to

court before whom justification was to be made the notice or a certified copy thereof required to be given by state insurance commissioner to county recorder of each county. This was a sufficient justification. [Libby v. Spokane Valley Land & Water Co.](#), 15 Idaho 467, 98 P. 715 (1908).

Surety Companies.

As soon as attack was made on appeal bond, duty devolves on appellant to have surety company justify, by producing documentary proof of authority. [Gonzaga University v. Masini](#), 44 Idaho 113, 255 P. 413 (1927).

An undertaking signed by an attorney in fact under a power of attorney authorizing him to sign the bond and who was the duly authorized and licensed agent of the company, as shown by the certificate of the director of insurance, was sufficiently executed even though the name of the company was incorrectly written. [Bothwell v. Keefer](#), 52 Idaho 737, 20 P.2d 199 (1933).

§ 41-2604. May be sole surety on bonds. — Whenever any bond, undertaking, recognizance or other obligation is by law, or by the charter, ordinances, rules or regulations of any municipality, board, body, organization, court, judge or public officer, required or permitted to be made, given, tendered or filed with surety or sureties, and whenever the performance of any act, duty or obligation, or the refraining from any act is required or permitted to be guaranteed, such bond, undertaking, obligation, recognizance or guaranty may be executed by a surety insurer qualified as in this code provided. Execution by such insurer of such bond, undertaking, obligation, recognizance or guaranty shall be in all respects a full and complete compliance with every requirement of every law, charter, ordinance, rule or regulation that such bond, undertaking, obligation, recognizance or guaranty shall be executed by one surety or by one or more sureties, or that such sureties shall be residents or householders, or freeholders, or either or both, or possess any other qualifications. All courts, judges, heads of departments, boards, bodies, municipalities and public officers of every character shall accept and treat such bond, undertaking, obligation, recognizance or guaranty, when so executed by such insurer, as conforming to, and fully and completely complying with every such requirement of every such law, charter, ordinance, rule or regulation.

History.

1961, ch. 330, § 557, p. 645.

CASE NOTES

Decisions Under Prior Law Justification.

When undertaking on appeal from justice's court was excepted to, appellant could, in lieu of a justification of sureties, file undertaking of surety company, but such undertaking had to be accompanied with documentary evidence showing prima facie that such surety company had qualified to do business in this state and that execution of such undertaking had been authorized by surety company, executed by agents or officers authorized to execute it, and notice of filing such undertaking and evidence

had to be given respondent. *Numbers v. Rocky Mt. Bell Tel. Co.*, 7 Idaho 408, 63 P. 381 (1900).

§ 41-2605. Certificate as evidence of authority to be sole surety. —

The certificate of authority of a surety insurer, issued as provided under this code, shall be evidence of the authority of the insurer to become and to be accepted as sole surety on all private bonds and contracts, and on all bonds, undertakings, recognizances and obligations required or permitted by law or the charter, ordinances, rules or regulations of any municipality, board, body, organization or public officer and of the solvency and credit of such insurer for all authorized purposes and its sufficiency as such surety.

History.

1961, ch. 330, § 558, p. 645.

§ 41-2606. Premiums on bonds — Allowance as expense costs — Limit as to amount. — (1) Any assignee, receiver, trustee, committee, guardian, curator, executor, administrator or other fiduciary required as such by law or the order of any court or judge to give bond or undertaking, may include as a part of the lawful expense of executing his trust such sum, paid to a surety insurer or to surety insurers authorized under the laws of this state to do so for becoming his surety on such bond or undertaking, as may be allowed by the court in which, or a judge before whom, he is required to account; and such court or judge shall allow in the settlement of the account of any such fiduciary the premium or premiums so paid to any such insurer or insurers, but not to exceed the premium for such bond or undertaking filed by such insurer or insurers with the director.

(2) In all other cases where, by the provisions of law, a corporate surety or guarantor is given or required as to an official bond except as to notaries public, the premium to be paid to any such insurer or insurers for becoming such surety or guarantor shall be paid out of the general funds of the divisions of government by or for which the person or persons covered by such bond or undertaking was appointed or elected, but the premiums shall in no case exceed the premiums filed by such insurer or insurers with the director for the individual, schedule or blanket bonds given or required.

History.

1961, ch. 330, § 559, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2607. Bond premiums as part of costs in actions and proceedings. — In all actions and proceedings a party entitled to recover disbursements therein shall be allowed and may tax and recover such sum paid a surety insurer authorized under the laws of this state to do so for executing any bond, recognizance, undertaking, stipulation or other obligation therein, not exceeding, however, one percent (1%) on the amount of the liability upon such bond, recognizance, undertaking, stipulation, or other obligation during each year the same has been in force.

History.

1961, ch. 330, § 560, p. 645.

CASE NOTES

Cited *Henderson v. Cominco Am., Inc.*, 95 Idaho 690, 518 P.2d 873 (1973).

Decisions Under Prior Law Excessive Premiums.

The amount of a premium on a cost bond demanded of one party by the other party in an action in district court was declared excessive in the cost bill filed in the suit, under former law restricting the amount of recovery of costs for such premiums to 1% of the amount of liability thereon. *Manion v. Waybright*, 59 Idaho 643, 86 P.2d 181 (1938).

§ 41-2608. Deposit for protection of surety. — It shall be lawful for any party of whom a bond, undertaking or other obligation is required to agree with his surety or sureties for the deposit of any or all moneys and assets for which such surety or sureties are or may be held responsible with a bank, savings bank, safe deposit or trust company authorized by law to do business as such, or other depository approved by the court or a judge thereof, if such deposit is otherwise proper, for the safe keeping thereof and in such manner as to prevent the withdrawal of such moneys and assets or any part thereof without the written consent of such surety or sureties or an order of the court or a judge thereof, made on such notice to such surety or sureties as such court or judge may direct.

History.

1961, ch. 330, § 561, p. 645.

CASE NOTES

Cited First Am. Title Co. v. Clark, 99 Idaho 10, 576 P.2d 581 (1978).

§ 41-2609. Release of surety on certain official bonds. — (1) The surety or the representative of any surety, upon the bond of any trustee, committee, guardian, assignee, receiver, executor or administrator, or other fiduciary, may apply by petition to the court wherein such bond is directed to be filed, or which may have jurisdiction of such trustee, committee, guardian, assignee, receiver, executor or administrator, praying to be relieved from further liability as such surety, for the acts or omissions of the trustee, committee, guardian, assignee, receiver, executor or administrator or other fiduciary, which may occur after the date of the order relieving such surety to be granted as herein provided for, and to require such trustee, committee, guardian, assignee, receiver, executor or administrator, or other fiduciary, to show cause why he should not account and said surety be relieved from such further liability as aforesaid, and said principal be required to give a new bond.

(2) Upon the filing of such petition, the court shall issue such order returnable at such time and place and to be served in such manner as the court shall direct, and may restrain such trustee, committee, guardian, assignee, receiver, executor or administrator or other fiduciary from acting except in such manner as it may direct to preserve the trust estate.

(3) Upon the return of the order to show cause, if the principal in the bond accounts in due form of law and files a new bond duly approved, then the court must make an order releasing the surety filing the petition as aforesaid, from liability upon the bond for any subsequent act or default of the principal. In default of the principal thus accounting and filing the new bond, the court shall make an order directing such trustee, committee, guardian, assignee, receiver, executor or administrator, or fiduciary to account in due form of law within thirty (30) days, and that if the trust fund or estate shall be found or made good and paid over or properly secured, such surety shall be discharged from any and all further liability as such for the subsequent acts or omissions of the trustee, committee, guardian, assignee, receiver, executor, or administrator, or fiduciary, after the date of the surety being so relieved or discharged and discharging such trustee, committee, guardian, assignee, receiver, executor or administrator, or fiduciary.

History.

1961, ch. 330, § 562, p. 645.

§ 41-2610. Estoppel to deny corporate power. — Any insurer giving any bond or recognizance referred to in sections 41-2604 through 41-2608[, Idaho Code,] shall be estopped, in any proceeding to enforce the liability which it has assumed to incur, to deny its corporate power to execute such instrument or assume such liability.

History.

1961, ch. 330, § 563, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion was added by the compiler to conform to the statutory citation style.

§ 41-2611. Deduction of bond premium from wages of employees. —
No firm, individual, railroad or other corporation doing business within this state shall collect or retain from the wages of the persons in their employ the cost of any guaranty or security furnished the said firm, individual or railroad or other corporation, covering the said employees, unless such employees shall have agreed to pay the premium on such guaranty or security.

History.

1961, ch. 330, § 564, p. 645.

§ 41-2612. Release of surety on bond of licensee or permittee. — (1) The surety or the representative of any surety upon any bond given on behalf or for the use and benefit of any person, firm, copartnership, association or corporation as a licensee or permittee under any law of the state of Idaho, or any municipality thereof, desiring to be released from subsequent liability and responsibility on such bond, shall serve a written notice upon the principal of such bond that on and after twenty (20) days from the date of service of such notice, the surety will withdraw as surety on such bond, and a copy of such notice shall forthwith be served upon the official with whom such bond is filed.

(2) Such notice shall be served personally upon the principal if found within the state of Idaho, and if not, by registered mail directed to the principal at his last known address. If the principal cannot be served either personally or by registered mail, service shall be made by publication of the notice in a newspaper of general circulation in the county of the residence or principal place of business of the principal, once a week for a period of two consecutive weeks. Service upon the principal shall be complete one week from the date of the last publication. The affidavit of the persons so serving such notice, with the registered return receipt card attached thereto, if such service has been made by mail, or the affidavit of the publisher of the newspaper, shall be sufficient proof of service of such notice.

(3) Proof of such service shall be filed with the official having custody of the bond and the liability of the surety shall cease after a period of twenty (20) days from the date of the service of such notice on the principal. If the principal fails within such twenty (20) day period to file with the proper official a new bond the permit or license shall be canceled and terminated.

History.

1961, ch. 330, § 565, p. 645.

STATUTORY NOTES

Cross References.

Publication of notices, § 60-109.

§ 41-2613. Surety companies authorized to become surety under arrest bond certificate — Certificate as cash bail. — (A) Right of qualified surety company to become surety with respect to guaranteed arrest bond certificates.

(1) Any domestic or foreign surety company which has qualified to transact surety business in this state by complying with the provisions of title 41, Idaho Code, may, in any year, become surety in an amount not to exceed two hundred (\$200) dollars with respect to any guaranteed arrest bond certificates issued in such year by an automobile club or association by filing with the department of insurance of this state an undertaking thus to become surety.

(2) Such undertaking shall be in form to be prescribed by the director of the department of insurance and shall state the following:

(a) The name and address of the automobile club or clubs or automobile association or associations with respect to the guaranteed arrest bond certificates of which the surety company undertakes to be surety.

(b) The unqualified obligation of the surety company to pay the fine or forfeiture in an amount not to exceed two hundred (\$200) dollars of any person who, after posting a guaranteed arrest bond certificate with respect to which the surety company has undertaken to be surety, fails to make the appearance to guarantee which the guaranteed arrest bond certificate was posted.

(3) The term “guaranteed arrest bond certificate,” as used herein, means any printed card or other certificate issued by an automobile club or association to any of its members, which said card or certificate is signed by such member and contains a printed statement that such automobile club or association and a surety company guarantee the appearance of the person whose signature appears on the card or certificate and that they will, in the event of failure of said person to appear in court at the time of trial, pay any fine or forfeiture imposed on such person in an amount not to exceed two hundred (\$200) dollars.

(B) Guaranteed arrest bond certificates as cash bail. Any guaranteed arrest bond certificate with respect to which a surety company has become surety, as provided in section (A) hereof shall, when posted by the person whose signature appears thereon, be accepted in lieu of cash bail in an amount not to exceed two hundred (\$200) dollars, as a bail bond, to guarantee the appearance of such person in any court, including municipal courts, in this state, at such time as may be required by the court, when such person is arrested for violation of any motor vehicle law of this state or ordinance of any municipality in this state (except for the offense of driving while intoxicated or for any felony) committed prior to the date of expiration shown on such guaranteed arrest bond certificates; provided, that any such guaranteed arrest bond certificate so posted as a bail bond in any court in this state shall be subject to the forfeiture and enforcement provisions with respect to bail bonds posted in criminal cases under the law as it now exists or may hereafter be amended, and that any such guaranteed arrest bond certificate posted as a bail bond in any municipal court in this state shall be subject to the forfeiture and enforcement provisions of the charter or ordinance of the particular municipality pertaining to bail bonds posted.

History.

I.C., § 41-2613, as added by 1963, ch. 36, § 1, p. 183.

STATUTORY NOTES

Compiler's Notes.

The name "commissioner of insurance" has been changed to "director of the department of insurance" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

Section 2 of S.L. 1963, ch. 36, read: "If any clause, phrase, word or section of this act be declared unconstitutional or invalid for any reason by any court of competent jurisdiction, the remaining portions of this act shall be and remain in full force and as valid as if such clause, phrase, word or section had not been incorporated herein.

Chapter 26A

MORTGAGE GUARANTY INSURANCE

Sec.

41-2650. Short title.

41-2651. Definitions.

41-2652. Authority to transact business.

41-2653. Limits of risk.

41-2654. Reserves.

41-2655. Schedule of premium charges.

41-2656. Advertising.

Idaho Code § 41-2650

§ 41-2650. Short title. — This chapter may be cited as the mortgage guaranty insurance act.

History.

I.C., § 41-2650, as added by 1972, ch. 79, § 1, p. 159.

§ 41-2651. Definitions. — In this chapter unless context or subject matter otherwise requires:

(1) “Mortgage guaranty insurance” means:

(a) Insurance against financial loss by reason of nonpayment of principal, interest and other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real property, provided the improvement on such real property is a residential building or buildings designed for occupancy by not more than four (4) families, or a condominium unit.

(b) Insurance against financial loss by reason of nonpayment of principal, interest and other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real property, provided the improvement on such real property is a building or buildings designed for occupancy by five (5) or more families or designed to be occupied for industrial or commercial purposes.

(c) Insurance against financial loss by reason of nonpayment of rent and other sums agreed to be paid under the terms of a written lease for the possession, use or occupancy of real property, provided the improvement on such real property is a building or buildings designed to be occupied for industrial or commercial purposes.

(2) “Authorized real property security” for the purposes of paragraphs (a) and (b) of subsection (1) of this section means an amortized note, bond or other evidence of indebtedness, not exceeding one hundred three percent (103%) of the fair market value of the real estate, secured by a mortgage, deed of trust, or other instrument constituting a first lien or charge on real property with any percentage in excess of one hundred percent (100%) being used to finance fees and closing costs on such indebtedness; provided:

(a) The real property loan secured in such manner is one which a bank, savings and loan association, or an insurance company, which is

supervised and regulated by a department of this state or an agency of the federal government, is authorized to make.

(b) The improvement on such real property is a building or buildings designed for occupancy as specified by paragraphs (a) and (b) of subsection (1) of this section.

(c) The lien on such real property may be subject and subordinate to the following:

(i) The lien of any public bond, assessment, or tax, when no installment, call or payment of or under such bond, assessment or tax is delinquent.

(ii) Outstanding mineral, oil or timber rights, rights-of-way, easements or rights-of-way of support, sewer rights, building restrictions or other restrictions or covenants, conditions or regulations of use, or outstanding leases upon such real property under which rents or profits are reserved to the owner thereof.

(3) “Contingency reserve” means an additional premium reserve established for the protection of policyholders against the effect of adverse economic cycles or losses.

(4) “Policyholders’ surplus” means the aggregate of paid-in capital stock, surplus and contingency reserve.

History.

I.C., § 41-2651, as added by 1972, ch. 79, § 1, p. 159; am. 1994, ch. 334, § 1, p. 1065; am. 2000, ch. 378, § 1, p. 1237; am. 2002, ch. 300, § 1, p. 856.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2000, ch. 378, declared an emergency. Approved April 14, 2000.

§ 41-2652. Authority to transact business. — Mortgage guaranty insurance may be transacted only by a stock insurer while possessing and maintaining paid-in capital stock of not less than one million five hundred thousand dollars (\$1,500,000) and surplus of not less than one million five hundred thousand dollars (\$1,500,000) and duly authorized to transact insurance in this state. The insurer shall not transact in any jurisdiction any kind of insurance other than mortgage guaranty insurance.

History.

I.C., § 41-2652, as added by 1972, ch. 79, § 1, p. 159; am. 1994, ch. 240, § 6, p. 751.

STATUTORY NOTES

Compiler's Notes.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-2653. Limits of risk. — (1) The insurer shall not retain risk as to any one (1) loan, or as to all loans secured by properties in a single housing tract or a contiguous tract, in an amount in excess of ten percent (10%) of the insurer's policyholders' surplus. In determining the amount of risk retained, applicable reinsurance in an assuming insurer authorized to transact insurance in this state or approved by the director shall be deducted from the total direct risk insured. For the purposes of this section "contiguous" means not separated by more than one-half (½) of a mile.

(2) The insurer shall not at any time have outstanding aggregate risk liability, net of applicable reinsurance, under mortgage guaranty insurance in amount in excess of twenty-five (25) times its policyholders' surplus.

(3) The director may waive the requirement of subsection (2) of this section upon a written request of the insurer and finding that the insurer is in compliance with any requirements or conditions imposed by the insurer's state of domicile and the insurer's policyholder surplus is reasonable in relationship to the insurer's aggregate insured risk and adequate to its financial needs. In reviewing a written request for approval to exceed the twenty-five (25) times its policyholders' surplus limitation, the director may retain outside experts to assist in the review. The insurer shall bear the cost of outside experts retained for the review.

(4) If at any time the insurer's outstanding risk liability as to mortgage guaranty insurance exceeds the limitations stated in subsection (2) of this section and the insurer has not received a written waiver from the director, the insurer shall accept no new mortgage guaranty insurance risks while such excess exists.

(5) The director may suspend or revoke the certificate of authority of an insurer which violates the provisions of this section.

History.

I.C., § 41-2653, as added by 1972, ch. 79, § 1, p. 159; am. 2010, ch. 131, § 1, p. 280; am. 2015, ch. 127, § 1, p. 321.

STATUTORY NOTES

Amendments.

The 2010 amendment, by ch. 131, in the last sentence in subsection (2), substituted “section” for “provision”; added subsection (4) and redesignated the subsequent subsections accordingly; and in subsection (5), inserted “and the insurer has not received a written waiver from the director.”

The 2015 amendment, by ch. 127, deleted former subsection (1), which read: “The insurer shall limit its coverage to an amount not exceeding twenty-five percent (25%) of the entire indebtedness to the insured, or in lieu thereof, the insurer may elect to pay the entire indebtedness to the insured, and acquire title to the authorized real property security” and redesignated former subsections (2) through (6) as present subsections (1) through (5).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2654. Reserves. — The insurer shall, as to mortgage guaranty insurance written by it, maintain unearned premium, contingency, and loss reserves as required by chapter 6, title 41, Idaho Code, except the unearned premium reserve for those policies covering a risk period of more than five (5) years shall be computed in accordance with formulae filed by the insurer and approved by the director.

History.

I.C., § 41-2654, as added by 1972, ch. 79, § 1, p. 159.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2655. Schedule of premium charges. — The insurer shall adopt, print and make available to persons desiring the same, a schedule of premium charges for mortgage guaranty insurance policies. The schedule shall show the entire amount of premium charge for each type of mortgage guaranty insurance policy issued by the insurer. The insurer shall not quote any premium charge to any person which is less than that currently available to others in this state for the same type of mortgage guaranty insurance policy. The amount by which any premium charge is less than that called for in the current schedule of premium charges is an unlawful rebate.

History.

I.C., § 41-2655, as added by 1972, ch. 79, § 1, p. 159.

§ 41-2656. Advertising. — No lending institution or lender, any of whose authorized real property securities are insured by mortgage guaranty insurance pursuant to this chapter, shall state in any form of advertising that the real property loans of the institution or lender are “insured loans” unless the advertising also clearly states that the loans are insured by private insurers named in the advertising; and no such advertising shall be published for dissemination in this state unless the insurer so advertised is authorized to transact such insurance by this state.

History.

I.C., § 41-2656, as added by 1972, ch. 79, § 1, p. 159.

Chapter 27

TITLE INSURANCE

Sec.

41-2701. Scope of chapter.

41-2702. Countersignature of policies.

41-2703. Other provisions especially applicable.

41-2704. Application of act — Business of title insurance.

41-2705. Supervision — Policy forms — Premiums.

41-2706. Title insurance rates — Justification.

41-2707. Filing of title insurance rates — Hearings.

41-2708. Determination of insurability — Prohibited risks — Rebates.

41-2709. Personal or controlled insurance.

41-2710. Requirements for agents.

41-2711. Requirements for title insurance related business — Bonds.

41-2712. Title insurance rating organization.

41-2713. Administration — Examination costs.

41-2714. Closing or settlement protection.

§ 41-2701. Scope of chapter. — This chapter applies only as to title insurance, as defined in section 41-508[, Idaho Code].

History.

1961, ch. 330, § 566, p. 645.

STATUTORY NOTES

Cross References.

Abstracters of title, § 54-101 et seq.

Compiler's Notes.

The bracketed insertion was added by the compiler to conform to the statutory citation style.

RESEARCH REFERENCES

ALR. — What amounts to a charge, encumbrance, or lien within the contemplation of title insurance policies. [87 A.L.R.3d 764](#).

Absence of effectual subdivision, or of street or easement, as within title insurance coverage. [8 A.L.R.4th 1246](#).

Title insurer's negligent failure to discover and disclose defect as basis for liability in tort. [19 A.L.R.5th 786](#).

§ 41-2702. Countersignature of policies. — A title insurer shall not issue a policy of title insurance or guaranteed certificate of title or other guaranty of title covering any property located within Idaho unless countersigned by a person, partnership, corporation or agency owning and maintaining a complete set of tract indexes or abstract records of the county in which such property is located; excepting, that any title insurer may issue such policies, guaranties or certificates directly and without such countersignature covering property in any county where it owns and maintains such indexes and records, or where no such indexes and records are owned and maintained.

History.

1961, ch. 330, § 567, p. 645.

§ 41-2703. Other provisions especially applicable. — The following other provisions of this code are, among other provisions, especially applicable as to title insurers:

- (1) Insuring powers, sections 41-312(3) and 41-508[, Idaho Code].
- (2) Capital funds required, section 41-313[, Idaho Code].
- (3) Deposit of title insurer, sections 41-316 and 41-316A[, Idaho Code].
- (4) Premium tax, section 41-402[, Idaho Code].
- (5) Definition of “title insurance”, section 41-508[, Idaho Code].
- (6) Reserve for losses, unearned premiums, section 41-611[, Idaho Code].
- (7) Special investments by title insurer, section 41-726[, Idaho Code].
- (8) Levy upon deposit of the insurer, section 41-810[, Idaho Code].

History.

1961, ch. 330, § 568, p. 645; am. 1994, ch. 240, § 11, p. 751.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertions in subsections (1) through (8) were added by the compiler to conform to the statutory citation style.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in

effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-2704. Application of act — Business of title insurance. — The provisions of chapter 27, title 41, Idaho Code, shall apply to all title insurance companies, title insurance rating organizations, title insurance agents, applicants for title insurance, policyholders and to all persons and business entities engaged in the business of title insurance. The business of title insurance shall include:

(1) The making, or proposing to make, as an insurer, guarantor or surety, or proposing any contract or policy of title insurance, which shall include all certificates, policies, binders, preliminary reports or other underwriting contracts and indorsements; (2) Transacting or proposing to transact any phase of title insurance including solicitations, negotiations preliminary to and execution of a contract of title insurance, and matters subsequent to the issuance of such contract; (3) The performance of any act included herein by a title insurer or a title insurance agent including, but not limited to, handling of escrows, settlements or closing incident to any contract or policy of title insurance; (4) The issuance of closing or settlement protection by a title insurer pursuant to [section 41-2714, Idaho Code](#); or (5) The doing, or proposing to do, any business in substance equivalent to any of the foregoing in the manner designated to evade the provisions of this chapter.

History.

[I.C., § 41-2704](#), as added by 1973, ch. 135, § 1, p. 252; am. 2015, ch. 275, § 1, p. 1132.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 275, added subsection (4) and redesignated former subsection (4) as subsection (5).

§ 41-2705. Supervision — Policy forms — Premiums. — (1) The business of title insurance shall operate in Idaho under the control and supervision of the director of the department of insurance as to the premium rates for basic classifications of policy and underwriting contracts in relation thereto, escrow fee, rates, closing or settlement protection, tract indexes and abstract records, and insurability as provided in title 41, Idaho Code, and under such uniform rules and regulations as may be from time to time prescribed by the director of the department of insurance. No title insurer shall engage in the title insurance business with respect to any interest in Idaho property other than under the applicable laws of the state of Idaho and under such rules and regulations as may be issued by the director of the department of insurance. No policy of title insurance or guarantee of any character on Idaho property shall be issued unless written by a title insurer complying with all the provisions of the laws of the state of Idaho, holding a certificate of authority under chapter 3, title 41, Idaho Code, and under such rules and regulations as may be issued by the director of the department of insurance.

(2) The rates for the premiums for title insurance and closing or settlement protection, the proportion of the rates for the premiums for title insurance and closing or settlement protection which is retained by a title insurance agent and the portion which is retained by a title insurer, shall be determined within the provisions of sections 41-2706, 41-2707 and 41-2708, Idaho Code, and the general provisions of title 41, Idaho Code; provided, not later than the effective date hereof each title insurer shall file its premium rates and basic policy classification in relation thereto, and the said rate so filed shall continue until changed as herein provided.

(3) The escrow fees of title insurers and title insurance agents shall be filed in accordance with rules promulgated by the director of the department of insurance.

(4) A title insurer shall file each form of certificate, policy, preliminary report, binder, closing or settlement protection, guaranty or other underwriting contract of title insurance prior to the delivery or issuance thereof in Idaho. The filing of the form of policies and contracts of title

insurance and the approval of the same shall be in accordance with sections 41-1812 and 41-1813, Idaho Code, as well as in conformance with chapter 27, title 41, Idaho Code.

(5) The provisions of [sections 41-2705 through 41-2708, Idaho Code](#), shall not apply to a title insurer contracting as a reinsurer of a title insurance policy on Idaho property where no primary liability is assumed.

(6) The director of the department of insurance, for the purpose of carrying out this chapter shall have the right to require title insurers issuing policies in Idaho and title insurance agents to submit such information as needed as to expense of operations, loss experience, underwriting risks and other material matters.

(7) Any person aggrieved by any order, act or regulation of the director hereunder shall have the rights and remedies set forth in chapter 52, title 67, Idaho Code.

History.

[I.C., § 41-2705](#), as added by 1973, ch. 135, § 2, p. 252; am. 2011, ch. 195, § 1, p. 556; am. 2015, ch. 275, § 2, p. 1132.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 195, added the subsection designations; in subsection (2), deleted “and the escrow fees of title insurers and title insurance agents” following “by a title insurer,” deleted “and each title insurer and title insurance agent shall file its escrow fee, in effect on January 1, 1973” following “relation thereto,” and deleted “and fee” following “the said rate”; and added subsection (3).

The 2015 amendment, by ch. 275, in subsections (1) and (4), inserted “closing or settlement protection” in the first sentence; and, in subsection (2), substituted “title insurance and closing or settlement protection, the proportion of the rates for the premiums for title insurance and closing or settlement protection which” for “title insurance, the proportion of the premium for title insurance which.”

Compiler’s Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase “the effective date hereof” in subsection (12) refers to the effective date of S.L. 1973, ch. 135, which was effective July 1, 1973.

CASE NOTES

Class Actions.

In considering a borrower’s Fed. R. Civ. P. 23 motion for class certification in an action alleging violation of this section and § 41-2707, the magistrate judge properly found that the borrower met the prerequisites for class certification; individual issues did not predominate because, although examining each class member’s file was necessary, this was an almost automatic process to determine whether the title policy showed a prior mortgage and whether the person received the discounted rate for a refinanced residential mortgage. *Lewis v. First Am. Title Ins. Co.*, 265 F.R.D. 536 (D. Idaho 2010).

§ 41-2706. Title insurance rates — Justification. — Title insurance premium rates for the basic classification of policies and underwriting contracts shall be those filed by a title insurer or a title insurance rating organization with justification and approved by order of the director of the department of insurance, or, those filed by the director of the department of insurance with his justification therefor, hearing thereon and order of the director, both as more particularly hereinafter set forth. The division of the total premium between a title insurer and a title insurance agent shall be filed by the title insurer. The insurance premium rates on basic classification of policies and said division of total premium shall be deemed fixed by the director of the department of insurance upon the director's order approving the same (i) as filed and justified by a title insurer or title insurance rating organization, with or without hearing, or (ii) following a hearing on the same as filed and justified by the director of the department of insurance.

(1) Justification of title insurance rates proposed by a title insurer, a title insurance rating organization, or the director of the department of insurance shall be filed with any proposed change of rate, and the filing shall be justified by:

- (a) the experience or judgment of the title insurer or title insurance rating organization or the director proposing the rates; or
- (b) its interpretation of any statistical data relied upon; or
- (c) the experience of other title insurers or title insurance rating organizations; or
- (d) any other factors which the title insurer or rating organization or director deems relevant.

(2) Rates made hereunder shall not be excessive, nor inadequate for the safety and soundness of the title insurer and title insurance agent, and shall not be unfairly discriminatory, and shall be adopted giving due consideration to:

- (a) desirability of stability of rate structures;

(b) necessity of assuring the financial solvency of a title insurer and title insurance agent in periods of economic depression by encouraging growth in assets of title insurers and title insurance agents in periods of high business and activity; and

(c) necessity for assuring a reasonable margin of underwriting profit sufficient to induce capital to be invested therein.

(3) Every title insurer and every title insurance rating organization shall adopt basic classifications of policies and contracts of title insurance which shall be used as the basis for rates. Rates for each classification may, at the discretion of the title insurer, or the title insurance rating organization filing the rate, be less than the cost of the expense elements in the case of smaller insurances, and the excess may be charged against larger insurances without rendering the rate unfairly discriminatory.

(4) When the director finds upon application by a title insurer that any rate for a particular kind or class of risk cannot practicably be filed before it is used, or any contract or kind of title insurance, by reason of rarity or peculiar circumstances, does not lend itself to advance determination and filing of rates, he may, under such rules and regulations as he may prescribe, permit such rate or contract or kind of title insurance to be used without a previous notice and thirty (30) day waiting period.

History.

I.C., § 41-2706, as added by 1973, ch. 135, § 3, p. 252; am. 2011, ch. 195, § 2, p. 556.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 195, in the first paragraph, deleted “and the escrow, closing or settlement fees shall be filed by the title insurer or agent as applicable and approved in the same manner as title insurance premiums” from the end of the second sentence and deleted “and said escrow fees” following “total premium” and “or title insurance agent” following “insurance rating organization” in the last sentence.

Compiler’s Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Cited *First Am. Title Co. v. Clark*, 99 Idaho 10, 576 P.2d 581 (1978).

§ 41-2707. Filing of title insurance rates — Hearings. — (1) Pursuant to such regulations as the director of the department of insurance may adopt, every title insurer or rating organization shall file with the director of the department of insurance its schedule of rates, basic classifications of policies or contracts, and rules pertaining thereto, and every modification of any of the foregoing, and the director of the department of insurance may file for modifications of any of such rates, basic classifications, and rules previously filed and approved or under consideration for approval. Every filing by a title insurer, rating organization of the director of the department of insurance shall propose an effective date and shall not be effective until:

(a) notice of such filing shall forthwith be given to title insurers qualified to do business in the state of Idaho and the filing shall be available for public inspection for thirty (30) days after its date of filing;

(b) any interested party may file comments on and objections to the proposed filing or any part set forth therein during said period of public inspection;

(c) in the event of a filing by a title insurer or rating organization, whether or not comment or objection thereon has been received, which, in the judgment of the director, meets the requirements of [section 41-2706, Idaho Code](#), the same may be approved without public hearing; and

(d) on any filing by an insurer or rating organization which upon review the director believes he may disapprove, or on a filing made by the director, the director shall hold a public hearing on or before sixty (60) days from the date of the original filing upon not less than ten (10) days' written notice of the hearing specifying in reasonable detail the matters to be considered at such hearing, notice to be given to every title insurer and title insurance rating organization, and to such other persons who have filed objection or comment thereto.

Upon such hearing, and not later than thirty (30) days thereafter, the director of the department of insurance shall order all or any part of such filing which he deems approved to be in effect as of the date of such order,

and if he finds the filing or a part thereof does not meet the requirements of title 41, Idaho Code, he shall issue an order specifying in what respects he finds that it so fails, stating when, within a reasonable period thereafter, such filing or a part thereof shall no longer be deemed effective if such filing or a part thereof has been effective prior thereto. Such order shall not affect any contract or policy made or issued prior to the effective date of said order changing any rate, or policy classification or form.

A title insurer, a title insurance rating organization or the director shall have the right at any time prior to an order thereon to withdraw a filing or a part thereof. Notice of such withdrawal shall be sent to each title insurer in the state that received notice of the original filing and to any person commenting on the filing.

(2) Any person or organization, other than a title insurer or title insurance rating organization, aggrieved by any filing in effect or proposed may make written application to the director specifying in reasonable detail the grounds of the objection relied upon by the applicant. The director, upon finding such application is made in good faith, there is reasonable cause for the grounds alleged by the applicant, that the applicant would be so aggrieved if his grounds are established, and that such grounds otherwise justify holding a hearing, shall, within ninety (90) days after receipt of such application, hold a hearing upon not less than thirty (30) days' written notice to the applicant and to every title insurer, title insurance rating organization, and agent involved in the filing challenged. If, after such hearing, the director finds that the filing or a part thereof does not meet the requirements of title 41, Idaho Code, he shall issue an order specifying in what respect he finds that such filing or part thereof fails to meet the requirements, and stating when, within a reasonable period thereafter, such filing or a part thereof shall be deemed no longer effective. Copies of the order shall be sent to the applicant and to every such title insurer and title insurance rating organization and agent. Such order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(3) No filing nor any modification thereof shall be disapproved if the rate in connection therewith meets the requirements of this chapter.

History.

I.C., § 41-2707, as added by 1973, ch. 135, § 4, p. 252; am. 1977, ch. 142, § 9, p. 303.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2708. Determination of insurability — Prohibited risks — Rebates. — (1) Insurability. No title insurance on real property in the state of Idaho shall be issued unless and until the title insurer or its agent:

- (a) Owns or leases, separately or jointly with another, tract indexes and abstract records of the county in which the property is located; and
- (b) Has caused to be made a search and examination of the title and a determination of insurability of title in accordance with sound title underwriting practices.

Evidence thereof for each policy shall be preserved and retained in the files of the title insurer or its agent. In lieu of retaining the original copy, the same may be reproduced by any photographic, photostatic, microfilm or microcard type of system or process that actually reproduces or forms a durable medium for reproducing the original.

(2) Prohibited risks. No title insurer doing business in this state shall guarantee the payment of deeds of trust or mortgages on real property. Nor shall any title insurer intentionally issue a title insurance policy without showing any outstanding enforceable recorded liens and encumbrances which are of record against the real property, except under circumstances the director of the department of insurance under his rulemaking powers may approve. Such guaranty of mortgage payments or intentional omission of such outstanding liens and encumbrances in violation hereof shall, upon proof thereof to the satisfaction of the director of the department of insurance, subject the insurer to a fine not to exceed two thousand dollars (\$2,000) and to the revocation of, suspension of, or refusal to renew a certificate of authority.

(3) Rebates. **Section 41-1314(1), Idaho Code**, shall be applicable to any person or entity and all employees, officers, agents, attorneys and solicitors thereof engaging in the title insurance business as to rebates and illegal inducements as in said section defined. The words “as inducement to such insurance” and “or in connection therewith” shall be construed to include but not be limited to underwriting premium, agent’s commission, abstracting charges, title examination fees, closing charges, escrow fees,

trustee fees, and foreclosure fees relating to deeds of trust. No insured in a policy nor any other person directly or indirectly connected with the transaction involving the issuance of a title insurance policy, including but not limited to mortgage brokers, real estate brokers and agents, builders or attorneys, nor any employee, agent or representative or solicitor thereof, shall knowingly receive or accept, directly or indirectly, any such rebate or illegal inducement. No title insurance company or title insurance agent shall quote or make any charge for title insurance to any person less than the currently filed rate for such risk with the department of insurance. Nothing in this section or this title shall be deemed to prohibit a title insurer or title insurance agent from providing a reimbursement or discount of the premium otherwise payable for a title insurance policy and for any escrow fees otherwise charged in a transaction handled by such title insurance company or title insurance agent involving a bona fide employee's residence. Each such person and entity giving or receiving a rebate, illegal inducement or a reduction in rate in violation of this section shall, in addition to the other penalties set forth in title 41, Idaho Code, for violation thereof, be liable for three (3) times the amount of such rebate, illegal inducement or reduced rate.

(4) Forwarding fees. No person forwarding or directing title insurance business to a title insurer or title insurance agent in Idaho, nor such insurer or agent receiving such business, shall give or receive anything of value, or a portion of the premium, therefor.

History.

I.C., § 41-2708, as added by 1973, ch. 135, § 5, p. 252; am. 2018, ch. 213, § 2, p. 481.

STATUTORY NOTES

Amendments.

The 2018 amendment, by ch. 213, in subsection (3), inserted the next-to-last sentence and inserted "in violation of this section" in the last sentence.

Compiler's Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch.

286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Premiums.

Title search.

Premiums.

Although a contract for the purchase of title insurance did not specify what the fee was, it was readily ascertainable by reference to statute and regulation, so when purchasers bought the insurance they in effect agreed to pay the established premium. *Inland Title Co. v. Comstock*, 116 Idaho 701, 779 P.2d 15 (1989).

Title Search.

Subdivision (1)(b) of this section does not create a duty in tort upon the part of title insurers to conduct a reasonable search and inspection of title. *Brown's Tie & Lumber Co. v. Chicago Title Co.*, 115 Idaho 56, 764 P.2d 423 (1988).

Cited *Anderson v. Title Ins. Co.*, 103 Idaho 875, 655 P.2d 82 (1982).

§ 41-2709. Personal or controlled insurance. — (1) Personal or controlled insurance means a policy of title insurance where the insured or one (1) of the insureds under such policy is, or the loss thereunder is payable to:

(a) the title insurer issuing such policy or to any person or entity directly or indirectly owning or controlling a majority of the voting stock or ownership in such title insurer, or any entity which is directly or indirectly controlled by a person or entity which also controls the title insurer described in this subsection (a); or

(b) a title insurance agent issuing such policy, or if the agent is a natural person, to his spouse, employer or employer's spouse or such other person related to said persons mentioned within the first degree by blood or marriage, or if the employer is an entity, to any person directly or indirectly owning or controlling the majority of voting stock or ownership of such entity, or any partner or member of an association, and if the agent is an entity, to any person directly or indirectly owning or controlling the majority of the voting stock or ownership of such entity or any corporation which directly or indirectly controls such person who also controls the title insurance agent.

(2) If the rates and charges for personal or controlled insurance in any one (1) year received from any one (1) source by a title insurer or by a title insurance agency exceed twenty-five per cent (25%), or if from all sources of personal and controlled insurance exceed fifty per cent (50%), of the total rates and charges received by such title insurer or title insurance agent in the same year, the excess shall be deemed unlawful rebates. For the purpose of this provision, if the interest of the title insurer or title insurance agent is or was held by the same in a fiduciary capacity for the beneficial owner thereof reflected by a writing between the parties, the issuance of such title insurance policy by which title is conveyed to or by such title insurer or title insurance agent shall not be deemed controlled insurance.

(3) The provisions of sections 41-1310, 41-1311 and 41-1312, Idaho Code, with respect to controlled insurance business shall be deemed to

include title insurance as well as the specific types of insurance named therein.

History.

I.C., § 41-2709, as added by 1973, ch. 135, § 6, p. 252.

§ 41-2710. Requirements for agents. — (1) A title insurance agent is a person owning or leasing separately or with another licensed agent a complete set of tract indexes and abstract records of each county for which policies are written and authorized in writing by a title insurer to solicit insurance, issue or countersign policies, or otherwise engage in the title insurance business. A title insurer shall not allow or permit any person, firm, association or corporation to act as its agent in relation to the issuance of any certificate, title insurance policy, or other underwriting contract unless such person, firm, association or corporation shall first have obtained a title insurance agent's license for each county for which policies are to be written from the director of the department of insurance. No person, firm, association or corporation shall act within this state as such agent for any title insurer without first having obtained a license from the director of insurance and filed a bond or cash deposit in lieu thereof as required herein.

(2) A separate agent's license for each county shall be issued by the director of the department of insurance upon due showing filed by the applicant upon forms to be provided by the director of the department of insurance and payment of a fee of fifty dollars (\$50.00), upon oath, that such applicant if an individual, is a bona fide resident of Idaho, if a firm or association is composed wholly of Idaho residents, or if a corporation is duly authorized or qualified to do business in the state, that the individual agent (or if a corporation or association, its managerial personnel who are going to exercise the license privilege) has reasonable experience or instruction in the field of title examinations and title insurance and the insurance laws of Idaho, that the applicant owns or leases, separately or with another, and maintains an adequate, complete set of tract indexes and abstract records of each county wherein he proposed to do business, and such application shall be endorsed by the title insurer with whom he proposed to do business that the proposed agent is known to have a good reputation and is worthy of public trust and that such title insurer knows of no fact or condition that would disqualify the agent from receiving the permit. An agent's license shall continue from the date issued until the first day of January of each year and shall be automatically renewed thereon upon the payment of the annual fee of fifty dollars (\$50.00) by the agent,

unless terminated as herein provided by the director of the department of insurance for cause. If the filing fee is not promptly paid, the applicant shall be subject to a late filing fee of two dollars (\$2.00) a day up to a maximum of one hundred dollars (\$100).

(3) Upon the termination of any agency by a title insurer or by the agent terminating, the title insurer shall immediately notify the director of the department of insurance in writing and a title insurance agent shall forthwith notify the director of the department of insurance of the name of a new title insurer with whom he proposes to do business, with the new title insurer's endorsement upon said notification. No title insurer shall allow the license of an agent for which it has vouched to continue unless all of the foregoing conditions have been complied with.

(4) The license of any title insurance agent may be denied, or the license suspended, revoked or renewal thereof refused, by the director of the department of insurance after notice and hearing if he finds that such license holder has:

- (a) Willfully violated any provisions of title 41, Idaho Code, or the rules issued thereunder;
- (b) Has intentionally made a material misstatement in the application for such license;
- (c) Has obtained or attempted to obtain such license by fraud or misrepresentation;
- (d) Has misappropriated or converted to his own use or illegally withheld money belonging to a title insurance company, an insured or any other person;
- (e) Has demonstrated his lack of trustworthiness or competence to act as such agent or been guilty of fraudulent or dishonest practices;
- (f) Has materially misrepresented the terms and conditions of a title insurance policy or contract, or the condition of the title represented thereby; or
- (g) Has failed to maintain a separate and distinct accounting of escrowed funds and has failed to maintain an escrow bank account or account separate and apart from all other accounts.

(5) Before any license is denied, suspended or revoked or renewal refused, the director shall give thirty (30) days' written notice by registered mail to the licensee or applicant and the title insurer represented by the agent, and if said agent or title insurer desires, to set a date of hearing and to allow the production of evidence by said parties or any other interested person as to the matter. The right and remedies of the parties shall be as set forth in chapter 52, title 67, Idaho Code. Any decision of the director of the department of insurance shall be made in writing and filed in his office and mailed to the title insurer and agent involved.

(6) As a condition of obtaining said license, the individual to be licensed for himself or the entity to be licensed for each employee escrow officer shall obtain, file and pay for a surety bond as provided for an escrow officer.

(7) Regular examination of the tract indexes, abstract records, and any other records to ascertain compliance with title 41, Idaho Code, and related rules, of a title agent after the first examination thereof by the director shall be limited to not more than every fifth year, unless the agent otherwise requests or the director has cause to believe the same does not comply with this chapter or the rules thereunder. The director shall prepare an examination report following each examination and shall provide such report to the title agent being examined affording the person up to twenty-eight (28) days within which to review, comment and request a hearing. Unless a hearing is requested in accordance with chapter 2, title 41, Idaho Code, the examination report shall be deemed available to the public notwithstanding the exemptions from disclosure provided in chapter 1, title 74, Idaho Code. In addition, if the title agency affirmatively requests, any reply to the examination report shall be deemed available to the public notwithstanding the exemptions from disclosure provided in chapter 1, title 74, Idaho Code. However, all working papers and other records produced by, obtained by or disclosed to the director or any other person in the course of an examination hereunder shall be made available to the person or company which was the subject of the examination in any proceeding pursuant to chapter 2, title 41, Idaho Code, but shall otherwise be held by the director as an exempt record not required to be made public.

History.

I.C., § 41-2710, as added by 1973, ch. 135, § 7, p. 252; am. 2010, ch. 96, § 1, p. 182; am. 2015, ch. 141, § 111, p. 379.

STATUTORY NOTES

Amendments.

The 2010 amendment, by ch. 96, added the subsection designations; and in subsection (7), in the first sentence, inserted “and any other records to ascertain compliance with title 41, Idaho Code, and related rules” and substituted and added the second through fifth sentences.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” twice in subsection (7).

Compiler’s Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2711. Requirements for title insurance related business — Bonds. — An escrow officer is an officer or an employee of a title insurance agent whose duties include any of the following: handling escrows, settlements, closings, and funds related thereto, except there are not to be included employees whose duties are wholly clerical or to act only as cosigners of escrow drafts. Each title insurance agent holding a license under this chapter, shall file with the director of insurance on or before January 1, of each year, and amend the same for new escrow officers employed within thirty (30) days of such employment, upon forms furnished by the director of insurance, the name and address of each person employed by it to serve in the capacity of an escrow officer. No title insurance agent shall permit any person to act as an escrow officer within this state beyond the time for compliance with the foregoing conditions. The director of insurance shall keep a record of the names and addresses of all escrow officers whose names have been duly filed with him as employed by title insurance agents within the state.

Every title insurance agent shall procure at its expense and file with the director of insurance a corporate surety bond of the type hereinafter set forth. The bond shall be in the minimum amount of ten thousand dollars (\$10,000) per county in which the title insurance agent is licensed and increased in increments of ten thousand dollars (\$10,000) corresponding to each additional person employed as an escrow officer in the county, provided that the maximum bond required of any title insurance agent shall be fifty thousand dollars (\$50,000) irrespective of the number of counties in which the agent is licensed or the number of escrow officers employed and provided that the manager or supervisor of the title insurance agent's principal office in a county shall not be counted as an escrow officer in determining the amount of the title insurance agent's bond. The bond shall run to the director of insurance and the condition of the bond shall be that the title insurance agent shall pay damages which may be sustained by the public in the conduct of title insurance related business as defined in [section 41-2704\(3\), Idaho Code](#), by reason of the title insurance agent's failure to comply with the provisions of this act and the regulations promulgated pursuant thereto by the director of insurance which shall include damages

sustained by reason of fraud, dishonesty, forgery, theft or wilful misapplication of funds committed by the title insurance agent and its employees. Such bond(s) may be by blanket form coverage. In lieu of such bond, cash or securities approved by the director in like amount may be deposited through the director of insurance under custodial arrangement as provided for deposits by insurers under [section 41-804, Idaho Code](#). The cash or securities so deposited shall be subject to the same condition as the bond.

If at any time it appears to the director that the terms of such bond may have been violated, the director may require the agent to appear in Boise with such records as he deems proper on the date not earlier than ten (10) days and not later than twenty-five (25) days after service of such notice, and there conduct an examination into the matter. If, upon examination the director is satisfied that the terms of the bond have been violated, he shall forthwith notify the surety and prepare a written statement covering the facts and deliver it to the attorney general of Idaho, with copy to the surety, whose duty it shall be to investigate the charges, and if satisfied that the terms of the bond have been violated, then to enforce the liability against the cash or securities, or by suit on said bond in Ada County in the name of the director of the department of insurance for the benefit of all parties who have suffered any loss because of the breach of the terms of said bond or deposit.

The provisions of this section as to escrow officers and the requirement for filing escrow fee rates with the director shall also be applicable to any corporation twenty-five per cent (25%) or more of the capital stock or ownership of which is directly or indirectly owned by a title insurer or title insurance agent, or any person or entity directly or indirectly owning a majority of the stock or ownership of such insurer or agent.

History.

[I.C., § 41-2711](#), as added by 1973, ch. 135, § 8, p. 252; am. 1975, ch. 209, § 1, p. 580.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The term “this act” in the third sentence in the second paragraph refers to S.L. 1975, Chapter 208, which is compiled as this section.

§ 41-2712. Title insurance rating organization. — (1) Finding. There are at the present time more than twelve (12) title insurers to which this chapter applies. Reasonable competition exists among said insurers with respect to classes of insurance written on titles. Said title insurers are not members of or subscribers to any rating organization with respect to their operation in Idaho. Some of said insurers presumably would become members of or subscribers to a rating organization if the same existed in relation to title insurance in this state. It is reasonable to assume that competition will continue to exist among the title insurers if ratemaking in concert were authorized and rating organizations were licensed in this state for such insurance. So long as reasonable competition continues in title insurance, the public welfare is served both by the making of rates in concert and by the making of rates by individual insurers, and no review thereof by the state is necessary or desirable in the public interest with respect to such class of insurance. So long as such competition continues, regulation adequate to protect the welfare of the citizens of the state with respect to such ratemaking in concert and such rating organization may be secured by licensing and periodic examination of the rating organization.

(2) Declaration of Policy. It is the purpose of this section to regulate title insurance within the scope hereby by allowing a title insurer or title insurance agent by becoming a member of a licensed title insurance rating organization making a filing under this chapter to satisfy its obligations for such filings; to authorize ratemaking in concert and the operation of the rating organization subject to regulations provided in this chapter; to retain and preserve the benefits flowing from reasonable competition; and to provide a review of such rates by the state for such classes of insurance within the scope of this chapter, if any, in which such reasonable competition may not hereafter exist.

(3) Rating Organization. A rating organization as defined, established and regulated in sections 41-1415 and 41-1416, Idaho Code, may be established for the title insurance business. The same may be licensed and commence business as therein provided upon hearing and findings by the director of the department of insurance in accordance herewith. Filings may be made thereby by a rating organization consisting of six (6) or more title insurers

receiving over fifty percent (50%) of the title insurance premiums on business in the state pursuant to sections 41-2706 and 41-2707, Idaho Code.

(4) After hearing upon thirty (30) days [days' notice] to the rating organization and its members and upon a finding by the director that reasonable competition no longer exists with respect to any or all of the classes of title insurance, and upon ninety (90) days' expiration after notice thereof, and for so long thereafter as such finding with respect thereto continues in effect, such rating organization may not make filings herein authorized as to such class or classes of title insurance.

(5) A rating organization subject to rules and regulations approved by the director shall admit any title insurer applying thereto as a member or as a subscriber to its rating service at reasonable cost and without discrimination or to withdraw therefrom. The cooperation of title insurance rating organizations and the cooperation of the rating organization and title insurer, and the concert action by title insurers under this general management control of the rating organization in ratemaking and other matters within the scope of title 41, Idaho Code, is hereby authorized, providing the premium rates for basic classification of policies, escrow fee rates, division of premium with agents and contracts are filed and approved in accordance with sections 41-2706 and 41-2707, Idaho Code.

(6) Deviations. Every member of or subscriber to a title insurance rating organization shall adhere to the filings made on its behalf by such organization, except that any title insurer member or subscriber may file with the director a decrease or increase to be applied to any and all elements of the rates produced by the rating system so filed for the class of title insurance upon a finding by the director that it is a proper rating unit for the application of such decrease or increase or proper to be applied to the rates for a particular area. Such deviation filing shall specify the basis for the modification and be accompanied by statistical or historical pattern justification. A copy of said filing shall be filed with the rating organization. Such deviation filing shall be subject to the provisions of sections 41-2706 and 41-2707, Idaho Code. Deviations shall be effective for one (1) year unless terminated sooner by order of the director.

(7) Appeals by the Minority. Any member of or subscriber to the rating organization may appeal to the director from any action or decision of the

rating organization and the director shall, after hearing held upon not less than fifteen (15) days' written notice to the applicant and the rating organization, issue an order approving the rating organization's action or directing it to give further consideration thereto, all within thirty (30) days following such order. On the appeal from the decision or action of the rating organization the director may, in the event he finds such decision or action was unreasonable, issue an order directing said rating organization to make additions to its filings on behalf of its members or subscribers, including approval of the filing suggested by the appellant, if either be in accordance herewith. Failure of a rating organization to take action or make a decision within sixty (60) days after submission of a proposal for deviation shall constitute a rejection thereof.

History.

I.C., § 41-2712, as added by 1973, ch. 135, § 9, p. 252.

STATUTORY NOTES

Compiler's Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance and commissioner to director on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in subsection (4) was added by the compiler to correct the enacting legislation.

§ 41-2713. Administration — Examination costs. — In the exercise of the powers of the director of the department of insurance to supervise and regulate title insurers, title insurance agents and title insurance rating organizations as provided in this chapter, as well as the powers of examination set forth in sections 41-219 and 41-220, Idaho Code, each title insurer, title insurance agent or rating organization regulated or examined shall, at the direction of the director, pay directly to such person charged with enforcing the law or regulations and making the examinations, actual travel expenses, a reasonable expense allowance, and compensation, at reasonable rates as approved by the director of the department of insurance, necessarily incurred in such matters on the presentation of a detailed account of such charges and expenses. A title insurer shall be charged for the original examination of a title insurance agent which the insurer desires to represent it, and a title insurer or rating organization shall be charged directly for hearings upon any hearing originated by filings made by it. The regulation and examination direct charges herein provided may include both field work and work in the office of the director necessary thereto.

Separately from the direct charges herein provided, the director may levy a general charge upon each title insurer in proportion to the gross premiums from title insurance written by it to defray the costs of regulation required by this chapter. Provided, nevertheless, a title insurer shall not be charged in any one (1) year, separately from the direct charges for examination under [section 41-219, Idaho Code](#), said plant examination and said hearings, in excess of one per cent (1%) of the gross premiums as defined in [section 41-402, Idaho Code](#), for title insurance written on Idaho real property in said year, provided the director in the first year after the effective date hereof may charge not in excess of two per cent (2%) of the gross premiums and may levy said charge after July 1, 1973, in advance based on the prior year's premiums. The director from year to year may carry forward any unexpended balance of general charges made in a rotating fund for said expenses to be incurred thereafter.

History.

[I.C., § 41-2713](#), as added by 1973, ch. 135, § 10, p. 252.

STATUTORY NOTES

Compiler's Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase “the effective date hereof” in the next-to-last sentence in the second paragraph refers to the effective date of S.L. 1973, Chapter 135, which was effective July 1, 1973.

§ 41-2714. Closing or settlement protection. — (1) A title insurer may issue closing or settlement protection to a buyer, borrower or lender that is a party to a transaction in which a title insurance policy will be issued. The closing or settlement protection shall be on a form filed with the department in accordance with [section 41-2705, Idaho Code](#).

(2) The closing or settlement protection shall be limited to indemnifying the buyer, borrower or lender insured against a loss due to either or both of the following actions of a licensed and authorized title insurance agent and is deemed for the purpose of this section to be within the business of title insurance as set forth in [section 41-2704, Idaho Code](#):

(a) Theft or misappropriation of closing or settlement funds in connection with a transaction in which a title insurance policy or title insurance policies will be issued by or on behalf of the title insurer issuing the closing or settlement protection.

(b) Failure to comply with the written closing instructions when agreed to by the title agent or title insurer, but only to the extent that the failure to follow the instructions relates to the status of the title to that interest in land or the validity, enforceability and priority of the lien of the mortgage on that interest in land.

(3) A rate must be charged and the rate charged by a title insurer for each transaction that includes closing protection coverage shall not be subject to any agreement requiring a division of rates or premiums collected on behalf of the title insurer. The issuance of a closing or settlement protection to a buyer, borrower or lender that is a party to a transaction in which a title insurance policy will be issued shall be considered to be one (1) transaction for which a single rate is charged and shall not result in a separate charge to each party. The rate shall:

(a) Be filed with the department in accordance with sections 41-2706 and 41-2707, Idaho Code;

(b) Be the only rate charged for closing protection; and

(c) Not exceed twenty-five dollars (\$25.00).

(4) A title insurer may not provide any other protection that purports to indemnify against improper acts or omissions of a person with regard to closing or settlement services.

(5) Except as otherwise provided for in closing or settlement protection, a buyer, borrower, lender, or title insurer retains all their respective rights and remedies in connection with losses suffered due to theft or misappropriation of closing or settlement funds or the failure to comply with written closing instructions. Nothing in this section shall be construed to require a buyer, borrower or lender to obtain closing or settlement protection. A failure to obtain closing or settlement protection shall not be construed as an error, omission or other breach of duty of a buyer, borrower or lender.

History.

I.C., § 41-2714, as added by 2015, ch. 275, § 3, p. 1132.

Chapter 28

ORGANIZATION AND CORPORATE PROCEDURES OF STOCK AND MUTUAL INSURERS

Sec.

41-2801. Scope of chapter.

41-2802. “Stock” insurer — “Mutual” insurer — Definitions.

41-2803. Applicability of general corporation statutes.

41-2804. Incorporation.

41-2805. Filing of articles.

41-2806 — 41-2808. Permit required to offer securities or to solicit qualifying applications for insurance — Penalty — Application for penalty — Application for permit to solicit qualifying mutual applications. [Repealed.]

41-2809. Investigation of proposed organization.

41-2810 — 41-2817. Granting or denial of permit — Terms of permit — Compliance — Permit as inducement — Modification or revocation of permit — Bond for permit — Escrow of funds — Subscriptions — Failure to complete or qualify. [Repealed.]

41-2818. Qualification for initial certificate of authority — Stock insurers.

41-2819. Subsequent financing. [Repealed.]

41-2820. Initial qualifications — Domestic mutuals.

41-2821. Formation of mutual insurer — Bond. [Repealed.]

41-2822. Applications for insurance in formation of mutual insurer.

41-2823. Formation of mutuals — Trust deposit of premiums — Issuance of policies.

41-2824. Formation of mutuals — Failure to qualify.

41-2825. Additional kinds of insurance — Mutuals.

41-2826. Amendment of articles of incorporation — Stock insurers.

41-2827. Amendment of articles of incorporation — Mutual insurer.

41-2828. Insurance business exclusive.

41-2829. Membership in mutuals.

41-2830. By-laws of mutual.

41-2831. Rights of mutual members in general.

41-2832. Meetings of members of mutual insurer.

41-2833. Special meetings of members of mutual insurer.

41-2834. Voting rights of mutual members.

41-2835. Directors.

41-2836. Notice of change of directors or officers.

41-2837. Prohibited pecuniary interest of officials.

41-2838. Management and exclusive agency contracts.

41-2839. Home office — Records — Assets — Penalty for unlawful removal.

41-2840. Vouchers for expenditures.

41-2841. Borrowed surplus.

41-2842. Participating policies.

41-2843. Dividends to stockholders.

41-2844. Dividends to policy holders.

41-2845. Illegal dividends — Penalty.

41-2846. Contingent liability of mutual members.

41-2847. Levy of contingent liability.

41-2848. Enforcement of contingent liability.

41-2849. Nonassessable policies — Mutual insurers.

41-2850. Nonassessable policies — Revocation of authority.

41-2851. Solicitations in other states.

41-2852. Impairment of capital or assets.

41-2853. Assessment of stockholders or members.

41-2854. Mutualization of stock insurers.

41-2854A. Mutualization of service corporations.

41-2855. Conversion of mutual insurer to stock insurer.

41-2856. Mergers and consolidations of stock insurers.

41-2857. Mergers and consolidations of mutual insurers.

41-2858. Bulk reinsurance — Mutual insurers.

41-2859. Mutual member's share of assets on liquidation.

41-2860. Equity securities of domestic stock insurance companies —
Statements of ownership.

41-2861. Recovery of profits resulting from unfair use of information.

41-2862. Restrictions on sale of equity securities.

41-2863. Purchases and sales which are exempt.

41-2864. Foreign or domestic arbitrage transactions exempt.

41-2865. "Equity security" defined.

41-2866. Conditions exempting equity securities.

41-2867. Rules and regulations.

41-2868. Proxy regulations.

41-2869. Purpose.

41-2870. Definitions.

41-2871. Use of book-entry systems.

41-2872. Health care provider contracts — Grievance procedure.

41-2873. Best price — Most favored nations clause prohibited.

§ 41-2801. Scope of chapter. — This chapter shall apply only to domestic stock insurers and domestic mutual insurers, except that sections 41-2849 (nonassessable policies, mutual insurers), 41-2872 (health care provider contracts) and 41-2873, Idaho Code, (best price — most favored nations clause prohibited) shall also apply as to foreign insurers.

History.

1961, ch. 330, § 569, p. 645; am. 1995, ch. 289, § 14, p. 967; am. 2003, ch. 103, § 1, p. 323; am. 2007, ch. 282, § 1, p. 813.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 282, inserted “41-2872 (health care provider contracts) and 41-2873, Idaho Code, (best price-most favored nations clause prohibited).”

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2802. “Stock” insurer — “Mutual” insurer — Definitions. — A “stock” insurer is as defined in section 41-301[, Idaho Code]. A “mutual” insurer is as defined in section 41-302[, Idaho Code].

History.

1961, ch. 330, § 570, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The bracketed insertions were added by the compiler to conform to the statutory citation style

§ 41-2803. Applicability of general corporation statutes. — (1) The applicable statutes of this state relating to the powers and procedures of domestic private corporations formed for profit shall apply to domestic stock insurers and to domestic mutual insurers, except where in conflict with the express provisions of this code and the reasonable implications of such provisions.

(2) Domestic stock insurers and domestic mutual insurers are exempt from the provisions of [section 30-21-213, Idaho Code](#).

History.

1961, ch. 330, § 571, p. 645; am. 1981, ch. 50, § 1, p. 76; am. 1999, ch. 65, § 6, p. 168; am. 2017, ch. 58, § 24, p. 91.

STATUTORY NOTES

Cross References.

Business organizations code, § 30-21-101 et seq.

General business corporations, § 30-29-101 et seq.

Amendments.

The 2017 amendment, by ch. 58, substituted “[section 30-21-213, Idaho Code](#)” for “[section 30-1-1622, Idaho Code](#)” at the end of subsection (2).

§ 41-2804. Incorporation. — (1) This section applies to stock and mutual insurers hereafter incorporated in this state.

(2) Incorporators. Seven (7) or more individuals who are citizens of this state may incorporate a stock insurer; ten (10) or more of such individuals may incorporate a mutual insurer.

(3) Articles of incorporation. The incorporators shall prepare and execute in triplicate articles of incorporation in accordance with the applicable provisions of chapters 21 and 30 [29], title 30, Idaho Code, known as the “General Business Corporation” laws of this state, but subject to the following requirements:

(a) In addition to matters required or permitted under such general business corporation laws which are not inconsistent with this provision or this code, the articles of incorporation shall set forth:

(i) The name of the corporation, which shall comply with [section 41-311, Idaho Code](#).

(ii) The kinds of insurance, as defined in this code, which the corporation is formed to transact.

(iii) If a stock corporation, its authorized capital stock, the number of shares of stock into which divided and the par value of each such share, which par value shall be at least one dollar (\$1.00). Shares without par value shall not be authorized.

(iv) If a stock corporation, the extent, if any, to which shares of its stock are subject to assessment.

(v) If a mutual corporation, the maximum contingent liability of its members, for payment of losses and expenses incurred, other than as to nonassessable policies issued as permitted under [section 41-2849, Idaho Code](#); such liability shall be as stated in the articles of incorporation, but shall not be less than one (1) nor more than six (6) annual premiums for the member’s policy.

(vi) The name and residence address of each incorporator, and whether each such incorporator is a citizen of this state.

(b) Articles of incorporation shall be filed as provided in [section 41-2805, Idaho Code](#).

History.

1961, ch. 330, § 572, p. 645; am. 1980, ch. 197, § 29, p. 433; am. 1990, ch. 383, § 1, p. 1061; am. 2003, ch. 163, § 3, p. 459; am. 2017, ch. 58, § 25, p. 91.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 58, substituted “chapters 21 and 30, title 30, Idaho Code” for “chapters 1 and 3, title 30, Idaho Code” near the middle of the introductory paragraph in subsection (3).

Compiler’s Notes.

The bracketed insertion in subsection (3) was added by the compiler to correct the 2017 amendment of this section, as chapter 29, title 30, Idaho Code, is entitled “General Business Corporations.”

Effective Dates.

Section 2 of S.L. 1990, ch. 383 declared an emergency. Approved April 12, 1990.

§ 41-2805. Filing of articles. — (1) The incorporators shall submit the executed articles of incorporation of a proposed stock or mutual insurer in triplicate to the director for review. If the director finds the articles to be in compliance with this code he shall deliver an original thereof to the attorney general for examination. After examining the articles, the attorney general shall return them to the director accompanied by his opinion certifying as to whether or not he has found the articles to be in accordance with the laws of this state and not inconsistent with the constitution of this state. If the attorney general has found the articles to be in accordance with law, the director shall, upon payment of the fees prescribed by law therefor, and except as provided in subsection (2) of this section, certify his approval upon each of the three (3) originals of the articles, file one (1) of such originals in his office and deliver two (2) of such originals to the incorporators, one (1) to be retained by the corporation as part of its corporate records, and one (1) to be filed with the secretary of state.

(2) If upon reviewing or examining the articles of incorporation as hereinabove provided, the director or the attorney general finds that the articles do not comply with this code or are not in accordance with the laws of this state, or are inconsistent with the constitution of this state, as the case may be, the director shall refuse to approve the articles and shall return all originals of the articles to the incorporators accompanied by a written statement of the defects in the articles or reasons upon which his refusal is based.

(3) The secretary of state shall not permit the filing with him or in his office of any such articles of incorporation unless the same bear the director's approval endorsed thereon as hereinabove provided. The director's approval, when so endorsed, shall be deemed to relate only to the form of the articles of incorporation, and shall not be deemed to constitute an approval or commitment by the director as to any other aspect or operation of the proposed insurer.

(4) The director and the attorney general shall perform all duties required of them under this section within a reasonable time after the articles of

incorporation have been submitted to the director as in subsection (1) above provided.

History.

1961, ch. 330, § 573, p. 645; am. 1980, ch. 197, § 30, p. 433; am. 2001, ch. 85, § 7, p. 211; am. 2003, ch. 103, § 2, p. 323.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Secretary of state, § 67-901 et seq.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 34 of S.L. 1980, ch. 197 read: “(1) Section 1 and sections 3 through 33 of this act shall be in full force and effect on and after July 1, 1980.

“(2) Section 2 of this act shall be in full force and effect on and after July 1, 1981.”

§ 41-2806 — 41-2808. Permit required to offer securities or to solicit qualifying applications for insurance — Penalty — Application for penalty — Application for permit to solicit qualifying mutual applications. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 2003, ch. 103, § 3, effective July 1, 2003: 41-2806. (1961, ch. 330, § 574, p. 645; am. 1987, ch. 81, § 1, p. 154).

41-2807. (1961, ch. 330, § 575, p. 645).

41-2808. (1961, ch. 330, § 576, p. 645).

§ 41-2809. Investigation of proposed organization. — Upon application of a new insurer for a certificate of authority, the director of the department of insurance shall promptly make an investigation of:

(1) The character, reputation, financial standing and purposes of the organizers, incorporators, and subscribers organizing the proposed insurer or organization; (2) The character, financial responsibility, insurance experience, and business qualifications of its proposed officers and directors; and (3) Such other aspects of the proposed insurer or financing as he may deem advisable.

History.

1961, ch. 330, § 577, p. 645; am. 2003, ch. 103, § 4, p. 323.

STATUTORY NOTES

Compiler's Notes.

The name of “commissioner of insurance” has been changed to “director of the department of insurance” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2810 — 41-2817. Granting or denial of permit — Terms of permit — Compliance — Permit as inducement — Modification or revocation of permit — Bond for permit — Escrow of funds — Subscriptions — Failure to complete or qualify. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 2003, ch. 103, § 3, effective July 1, 2003: 41-2810. (1961, ch. 330, § 578, p. 645; am. 2001, ch. 85, § 8, p. 211).

41-2811. (1961, ch. 330, § 579, p. 645).

41-2812. (1961, ch. 330, § 580, p. 645).

41-2813. (1961, ch. 330, § 581, p. 645).

41-2814. (1961, ch. 330, § 582, p. 645).

41-2815. (1961, ch. 330, § 583, p. 645).

41-2816. (1961, ch. 330, § 584, p. 645).

41-2817. (1961, ch. 330, § 585, p. 645).

§ 41-2818. Qualification for initial certificate of authority — Stock insurers. — A newly formed domestic stock insurer shall be entitled to a certificate of authority only when its entire authorized capital stock has been subscribed for and paid for in full, and it has fulfilled the other requirements for the certificate of authority as applicable under this code to the kind or kinds of insurance proposed to be transacted. The director shall not issue a certificate of authority to any such insurer which does not meet the requirements of this section.

History.

1961, ch. 330, § 586, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2819. Subsequent financing. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 587, p. 645, was repealed by S.L. 2003, ch. 103, § 3, effective July 1, 2003.

§ 41-2820. Initial qualifications — Domestic mutuals. — When newly organized, a domestic mutual insurer may be authorized to transact any one of the kinds of insurance defined in [sections 41-502 through 41-506, Idaho Code](#), if it has otherwise complied with the provisions of title 41, Idaho Code, and possesses and maintains surplus funds as provided in section 41-313 or 41-3102A, Idaho Code.

History.

1961, ch. 330, § 588, p. 645; am. 1995, ch. 96, § 2, p. 273.

§ 41-2821. Formation of mutual insurer — Bond. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 589, p. 645, was repealed by S.L. 1995, ch. 96, § 3, effective March 13, 1995.

§ 41-2822. Applications for insurance in formation of mutual insurer.

— (1) Upon receipt of the director's approval of the bond or deposit as provided in [section 41-2821, Idaho Code](#), the proposed domestic mutual insurer may commence solicitation of such requisite applications for insurance policies as it may accept, and may receive deposits of premiums thereon.

(2) All such applications shall be in writing signed by the applicant, covering subjects of insurance resident, located or to be performed in this state.

(3) All such applications shall provide that:

(a) Issuance of the policy is contingent upon the insurer qualifying for and receiving a certificate of authority;

(b) No insurance is in effect unless and until the certificate of authority has been issued; and

(c) The prepaid premium or deposit, and membership or policy fee, if any, shall be refunded in full to the applicant if organization is not completed and the certificate of authority is not issued and received by the insurer before a specified reasonable date, which date shall be not later than one (1) year after the date of the certificate of incorporation.

(4) All qualifying premiums collected shall be in cash.

(5) Solicitation for such qualifying applications for insurance shall be by licensed agents of the corporation, and the director shall, upon the corporation's application therefor, issue temporary agent's licenses expiring on the date specified pursuant to subdivision (c) above to individuals qualified as for a resident agent's license except as to the taking or passing of an examination. The director may suspend or revoke any such license for any of the causes and pursuant to the same procedures as are applicable to suspension or revocation of licenses of agents in general [insurance producers] under chapter 10, title 41, Idaho Code.

History.

1961, ch. 330, § 590, p. 645; am. 1972, ch. 164, § 5, p. 376.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 41-2821, referred to in subsection (1) of this section, was repealed by S.L. 1995, ch. 96, § 3.

The bracketed insertion in subsection (5) was added by the compiler to reflect the 2001 amended language of chapter 10, title 41, Idaho Code.

Effective Dates.

Section 8 of S.L. 1972, ch. 164 provided the act should take effect from and after January 1, 1973.

§ 41-2823. Formation of mutuals — Trust deposit of premiums — Issuance of policies. — (1) All sums collected by a domestic mutual corporation as premiums or fees on qualifying applications for insurance therein shall be deposited in trust in a bank or trust company in this state under a written trust agreement approved by the director and consistent with this section and with section 41-2822(3)(c)[, Idaho Code]. The corporation shall file an executed copy of such trust agreement with the director.

(2) Upon issuance to the corporation of a certificate of authority as an insurer for the kind of insurance for which such applications were solicited, all funds so held in trust shall become the funds of the insurer, and the insurer shall thereafter in due course issue and deliver its policies for which premiums had been paid and accepted. The insurance provided by such policies shall be effective as of the date of the certificate of authority or thereafter as provided by the respective policies.

History.

1961, ch. 330, § 591, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of the first sentence in subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-2824. Formation of mutuals — Failure to qualify. — If the proposed domestic mutual insurer fails to complete its organization and to secure its original certificate of authority within one (1) year from and after date of its certificate of incorporation, the corporation shall transact no further business, and the director shall return or cause to be returned to the persons entitled thereto all advance deposits or payments of premiums held in trust under section 41-2823[, Idaho Code].

History.

1961, ch. 330, § 592, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of the section was added by the compiler to conform to the statutory citation style.

§ 41-2825. Additional kinds of insurance — Mutuals. — A domestic mutual insurer, after being authorized to transact one (1) kind of insurance, may be authorized to transact such additional kinds of insurance as are permitted under [section 41-312, Idaho Code](#), while otherwise in compliance with this code and while maintaining unimpaired surplus funds in an amount not less than the amount of paid-in capital stock required of a domestic stock insurer transacting like kinds of insurance, subject further to the additional surplus requirements of [section 41-313, Idaho Code](#), applicable to such a stock insurer.

History.

1961, ch. 330, § 593, p. 645; am. 1995, ch. 96, § 4, p. 273.

STATUTORY NOTES

Effective Dates.

Section 9 of S.L. 1995, ch. 96 declared an emergency. Approved March 13, 1995.

§ 41-2826. Amendment of articles of incorporation — Stock insurers.

— (1) A domestic stock insurer may amend its articles of incorporation or bylaws for any lawful purpose through procedures prescribed by the statutes of this state as to business corporations in general, and by complying with the requirements of subsection (2) below.

(2) No such amendment to an insurer's articles of incorporation shall be effectuated until a fully executed copy of the certificate of amendments has been filed with the director, and has been approved by him. The director shall approve the amendment unless found by him not to be in compliance with law. At time of filing, the fee therefor shall be paid in the amount prescribed in section 41-401[, Idaho Code] (fee schedule).

History.

1961, ch. 330, § 594, p. 645; am. 2004, ch. 239, § 1, p. 702.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Secretary of state, § 67-901 et seq.

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of subsection (2) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2827. Amendment of articles of incorporation — Mutual insurer. — (1) A domestic mutual insurer heretofore or hereafter formed may amend its articles of incorporation for any lawful purpose by affirmative vote of a majority of those of its members present or represented by proxy at any regular annual meeting of its members, or at any special meeting called for the purpose.

(2) Upon adoption of such an amendment the insurer shall make a certificate thereof in triplicate under its corporate seal, setting forth such amendment and the date and manner of the adoption thereof, which certificate shall be executed by the insurer's president or vice-president and secretary or assistant secretary, and be verified by one of them before a notary public. The insurer shall deliver to the director the triplicate originals of the certificate together with the filing fee specified therefor in section 41-401[, Idaho Code] (fee schedule). The director shall transmit one (1) original of the proposed amendment to the attorney general for examination. If the director and the attorney general find that the certificate and the amendments comply with law, the director shall endorse his approval upon each of the triplicate originals, place one (1) set on file in his office and return the remaining originals to the insurer. The insurer shall file one (1) of such originals with the secretary of state and retain the third original for its corporate records. The amendment shall be effective when filed with the secretary of state.

(3) If the director or the attorney general find that the proposed amendment or certificate does not comply with law, the director shall not approve the same, and shall return all certificates of amendment to the insurer together with his written statement of reasons for nonapproval. The filing fee shall not be returnable.

History.

1961, ch. 330, § 595, p. 645; am. 1985, ch. 251, § 2, p. 584.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Secretary of state, § 67-901 et seq.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of the second sentence in subsection (2) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2828. Insurance business exclusive. — A domestic insurer heretofore or hereafter formed shall not have corporate power to engage, and shall not directly or indirectly engage, in any business other than the insurance business and in business activities reasonably and necessarily incidental to such insurance business; except that a title insurer may also engage in business as an escrow agent.

History.

1961, ch. 330, § 596, p. 645.

§ 41-2829. Membership in mutuals. — (1) Each policyholder of a domestic mutual insurer, other than of a reinsurance contract, is a member of the insurer during the period of the insurance with all rights and obligations of such membership, and the policy shall so specify.

(2) Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, estate, trustee or fiduciary may be a member of a mutual insurer.

History.

1961, ch. 330, § 597, p. 645.

CASE NOTES

Cited *Kelso & Irwin, P.A. v. State Ins. Fund*, 134 Idaho 130, 997 P.2d 591 (2000).

§ 41-2830. By-laws of mutual. — (1) A domestic mutual insurer shall have by-laws for the government of its affairs. The insurer's initial board of directors shall adopt original by-laws, subject to the approval of the insurer's members at the next meeting of members.

(2) The by-laws shall contain provisions, consistent with this code, relating to: (a) The voting rights of members; (b) Election of directors, and the number, qualifications, terms of office and powers of directors; (c) Annual and special meetings of members; (d) The number, designation, election, terms and powers and duties of the respective corporate officers; (e) Deposit, custody, disbursement and accounting for corporate funds; (f) Fidelity bonds covering such officers and employees of the insurer handling its funds, to be issued by corporate surety and to be in such amount as may be reasonable; and (g) Such other matters as may be customary, necessary, or convenient for the management or regulation of corporate affairs.

(3) The insurer shall promptly file with the director a copy, certified by the insurer's secretary, of its by-laws and of every modification thereof or addition thereto. The director shall disapprove any by-law provision deemed by him, after a hearing held thereon, to be unlawful, unreasonable, inadequate, unfair or detrimental to the proper interests or protection of the insurer's members or any class thereof. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any by-law provision so disapproved.

History.

1961, ch. 330, § 598, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2831. Rights of mutual members in general. — (1) A domestic mutual insurer is owned by and shall be operated in the interest of its members.

(2) With respect to the management, records and affairs of the insurer, a member of a mutual insurer shall have the same character of rights and relationship as a stockholder has toward a domestic stock insurer, subject to the provisions of this code.

History.

1961, ch. 330, § 599, p. 645.

§ 41-2832. Meetings of members of mutual insurer. — (1) Meetings of members of a domestic mutual insurer shall be held in the city or town of its registered office in this state, except as may otherwise be provided in the insurer's by-laws with the director's approval.

(2) Each such insurer shall, during the first six (6) months of each calendar year, hold the annual meeting of its members to fill vacancies existing or occurring in the board of directors, receive and consider reports of the insurer's officers as to its affairs and transact such other business as may properly be brought before it.

(3) Notice of the time and place of the annual meeting of members shall be given by imprinting such notice plainly on the policies issued by the insurer. Any change of the date or place of the annual meeting shall be made only by an annual meeting of members. Notice of such change may be given:

(a) By imprinting such new date or place on all policies which will be in effect as of the date of such changed meeting; or

(b) Unless the director otherwise orders, notice of the new date or place need be given only through policies issued after the date of the annual meeting at which such change was made and in premium notices and renewal certificates issued during the twenty-four (24) months immediately following such meeting.

(4) If more than six (6) months are allowed to elapse after an annual meeting of members is due to be held and without such annual meeting being held, the director shall, upon written request of any officer, director, or member of the insurer, cause written notice of such meeting to be given to the insurer's members, and the meeting shall be held as soon as reasonably possible thereafter. The director shall attend the meeting.

(5) Subsections (2) and (3) above shall not apply as to a fraternal insurer, as defined in section 41-3101(2)[, Idaho Code], which shall hold the annual meeting of its members and give notice thereof, at such reasonable time and place and in such reasonable manner as may be provided by the insurer's by-laws with the director's approval.

History.

1961, ch. 330, § 600, p. 645.

STATUTORY NOTES**Compiler's Notes.**

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in subsection (5) was added by the compiler to conform to the statutory citation style.

§ 41-2833. Special meetings of members of mutual insurer. — (1) A special meeting of the members of a mutual insurer may be held for any lawful purpose. The meeting shall be called by the corporate secretary pursuant to request of the insurer's president or of its board of directors, or upon request in writing signed by not less than one-tenth (1/10) of the insurer's members. The meeting shall be held at such time as the secretary may fix, but not less than ten (10) nor more than thirty (30) days after receipt of the request. If the secretary fails to issue such call, the president, directors, or members making the request may do so.

(2) Not less than ten (10) days' written notice of the meeting shall be given. Notice addressed to the insurer's members at their respective post office addresses last of record with the insurer and deposited, postage prepaid, in a letter depository of the United States post office, shall be deemed to have been given when so mailed. In lieu of mailed notice the insurer may publish the notice in such publication or publications as shall afford a majority of its members a reasonable opportunity to have actual advance notice of the meeting. The notice shall state the purposes of the meeting, and no business shall be transacted at the meeting of which notice was not so given.

History.

1961, ch. 330, § 601, p. 645.

§ 41-2834. Voting rights of mutual members. — (1) Each member of a mutual insurer is entitled to one (1) vote upon each matter coming to a vote at meetings of members.

(2) A member shall have the right to vote in person or by his written proxy filed with the corporate secretary not less than five (5) days prior to the meeting. No such proxy shall be made irrevocable, nor be valid beyond the earlier of the following dates: (a) The date of expiration set forth in the proxy; or (b) The date of termination of membership; or (c) Five (5) years from the date of execution of the proxy.

(3) No member's vote upon any proposal to divest the insurer of its business or assets, or the major part thereof, shall be registered or taken except in person or by proxy newly executed and specific as to the matter to be voted upon.

History.

1961, ch. 330, § 602, p. 645.

§ 41-2835. Directors. — (1) The affairs of every domestic insurer shall be managed by a board of directors consisting of not less than five (5) directors nor more than fifteen (15) directors.

(2) Directors shall be elected by the members or stockholders of a domestic insurer at the annual meeting of stockholders or members. Directors may be elected for terms of not more than five (5) years each and until their successors are elected and have qualified, and if to be elected for terms of more than one (1) year the insurer's bylaws shall provide for a staggered term system under which the terms of a proportionate part of the members of the board of directors shall expire on the date of each annual meeting of stockholders or members.

(3) A director of a mutual insurer shall be a policyholder thereof.

(4) As to an insurer operating as an authorized insurer only in the state of Idaho, a majority of the members of the insurer's board of directors shall be citizens of and shall actually reside in this state.

(5) Notwithstanding the provisions of subsection (1) of this section, a service corporation converted to a mutual insurer pursuant to [section 41-2854A, Idaho Code](#), shall be managed by a board of directors consisting of not less than five (5) directors nor more than twenty-five (25) directors. In the case of a service corporation that was a professional service corporation under chapter 34, title 41, Idaho Code, immediately prior to the effective date of its plan of mutualization, the board of directors after the effective date may include professionals of the kind or kinds designated in the corporation's articles of incorporation as participant licensees immediately prior to such effective date, so long as a majority of directors are not professionals of the kind or kinds so designated. In the case of a service corporation that was a hospital service corporation under chapter 34, title 41, Idaho Code, immediately prior to the effective date of its plan of mutualization, the board of directors after the effective date shall include one (1) or more individuals representing a hospital or hospitals, so long as a majority of directors are not representing or employed by any hospital. In the case of a service corporation that was a combined professional service and hospital service corporation under chapter 34, title 41, Idaho Code,

immediately prior to the effective date of its plan of mutualization, the board of directors after the effective date shall include one (1) or more individuals representing a hospital or hospitals, and one (1) or more professionals of the kind or kinds designated in the corporation's articles of incorporation as participant licensees immediately prior to such effective date, so long as a majority of directors are neither such professionals nor representing or employed by any hospital, nor any combination thereof; further, the number of directors who are hospital representatives shall equal the number of directors who are professionals of the kind or kinds designated as participant licensees in the corporation's articles of incorporation in effect immediately prior to such effective date. Notwithstanding the provisions of subsection (3) of this section, a director elected as a hospital representative need not be a policyholder so long as the represented hospital is a policyholder.

History.

1961, ch. 330, § 603, p. 645; am. 1994, ch. 78, § 2, p. 173; am. 2003, ch. 163, § 4, p. 459.

STATUTORY NOTES

Effective Dates.

Section 7 of S.L. 1994, ch. 78 provided: "An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2 and 7 of this act shall be in full force and effect on and after passage and approval, and Sections 3, 4, 5 and 6 of this act shall be in full force and effect on and after January 1, 1995."

§ 41-2836. Notice of change of directors or officers. — An insurer shall promptly give the director written notice of any change of personnel among its directors or principal officers.

History.

1961, ch. 330, § 604, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2837. Prohibited pecuniary interest of officials. — (1) Any officer or director, or any member of any committee or an employee of a domestic insurer who is charged with the duty of investing or handling the insurer's funds shall not deposit or invest such funds except in the insurer's corporate name; shall not borrow the funds of such insurer; shall not be pecuniarily interested in any loan, pledge or deposit, security, investment, sale, purchase, exchange, reinsurance, or other similar transaction or property of such insurer except as a stockholder or member; shall not take or receive to his own use any fee, brokerage, commission, gift, or other consideration for or on account of any such transaction made by or on behalf of such insurer.

(2) No insurer shall guarantee any financial obligation of any of its officers or directors.

(3) This section shall not prohibit such a director or officer, or member of a committee or employee from becoming a policyholder of the insurer and enjoying the usual rights so provided for its policyholders, nor shall it prohibit any such officer, director or member of a committee or employee from participating as beneficiary in any pension trust, deferred compensation plan, profit sharing plan or stock option plan authorized by the insurer and to which he may be eligible, nor shall it prohibit any director or member of a committee from receiving a reasonable fee for lawful services actually rendered to such insurer.

(4) The director may, by regulations from time to time, define and permit additional exceptions to the prohibition contained in subsection (1) of this section solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer, or to a corporation or firm in which a director is interested, for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of such director or such corporation or firm.

History.

1961, ch. 330, § 605, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2838. Management and exclusive agency contracts. — (1) No domestic insurer shall hereafter make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, or, if an officer, director or otherwise part of the insurer's management, is to receive any commission, bonus or compensation based upon the volume of the insurer's business or transactions, unless the contract is filed with and approved by the director. The contract shall be deemed approved unless disapproved by the director within twenty (20) days after date of filing, subject to such reasonable extension of time as the director may require by notice given within such twenty (20) days. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor.

(2) Any such contract, or contract holder, shall provide that any such manager or producer of its business shall within ninety (90) days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, including the emoluments received therefrom by the respective directors, officers, and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.

(3) The director shall disapprove any such contract if he finds that it: (a) Subjects the insurer to unreasonable or excessive charges; or (b) Is to extend for an unreasonable length of time; or (c) Does not contain fair and adequate standards of performance; or (d) Contains other inequitable provision or provisions which impair the proper interests of stockholders or policyholders of the insurer.

(4) The director may, after a hearing held thereon, withdraw his approval of any such contract theretofore approved by him, if he finds that the bases of his original approval no longer exist, or that the contract has, in actual

operation, shown itself to be subject to disapproval on any of the grounds referred to in subsection (3) above.

(5) This section does not apply as to contracts entered into prior to the effective date of this code, nor to extensions or amendments to such contracts.

History.

1961, ch. 330, § 606, p. 645; am. 1969, ch. 214, § 67, p. 625.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase “the effective date of this code” in subsection (5) refers to the effective date of S.L. 1961, Chapter 330, which was effective January 1, 1962.

§ 41-2839. Home office — Records — Assets — Penalty for unlawful removal. — (1) Except as provided in subsection (5) of this section, every domestic insurer shall have and maintain its principal place of business and home office in this state, and shall keep therein accurate and complete accounts and records of its assets, transactions, and affairs in accordance with the usual and accepted principles and practices of insurance accounting and recordkeeping as applicable to the kinds of insurance transacted by the insurer.

(2) Every domestic insurer shall have and maintain its assets in this state, except as to:

- (a) Real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state;
- (b) Such property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and “regional home offices” located outside this state as referred to in subsection (4) below; and
- (c) Such assets of any insurer that has redomesticated to this state pursuant to [section 41-342, Idaho Code](#), and satisfies the conditions of subsection (5) of this section.

(3) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger or consolidation approved by the director under this code, or for such reasonable purposes and periods of time as may be approved by the director in writing in advance of such removal, or concealment of such records or assets or such material part thereof from the director, is prohibited. Any person who removes or attempts to remove such records or assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the intent to remove the same from this state, or who conceals or attempts to conceal the same from the director, in violation of this section, shall upon conviction thereof be guilty of a felony, punishable by a fine of not more than ten thousand dollars (\$10,000), or by imprisonment in the penitentiary for not more than five (5) years, or by both

such fine and imprisonment in the discretion of the court. Upon any removal or attempted removal of such records or assets or upon retention of such records or assets or material part thereof outside this state, beyond the period therefor specified in the director's consent under which the records were so removed thereat, or upon concealment of or attempt to conceal records or assets in violation of this section, the director may institute delinquency proceedings against the insurer pursuant to the provisions of chapter 33, title 41, Idaho Code.

(4) This section shall not be deemed to prohibit or prevent an insurer from:

(a) Establishing and maintaining branch offices or "regional home offices" in other states where necessary or convenient to the transaction of its business and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the director at his request.

(b) Having, depositing or transmitting funds and assets of the insurer in or to jurisdictions outside of this state required by the law of such jurisdiction or as reasonably and customarily required in the regular course of its business.

(c) Using custodial arrangements for the holding of book-entry securities owned by the insurer, either in or outside of this state, and either segregated from or commingled with securities owned by others, if the arrangements conform to rules adopted by the director for safeguarding the assets and facilitating the director's examination of insurers using such custodial arrangements.

(5) A stock insurer that has redomesticated to this state pursuant to [section 41-342, Idaho Code](#), is not required to maintain its home office and principal place of business in this state and is not required to maintain its assets in this state so long as:

(a) The majority of the stock of the insurer is owned directly or indirectly by a mutual insurance holding company that maintains its home office and principal place of business in this state;

(b) The insurer can and shall produce the accounts and records of the insurer in their entirety in this state upon request from the director in a form satisfactory to the director;

(c) Material administrative and financial activities of the insurer are conducted in this state, initial evidence of which is submitted by the insurer under oath to the director as part of the insurer's application for a certificate of authority or certificate of redomestication under [section 41-342, Idaho Code](#);

(d) At least one (1) officer and one (1) director of the insurer are residents of this state. The officer and director contemplated in this paragraph shall not be the same person; and

(e) In addition to those examination expenses payable by the insurer under [section 41-228, Idaho Code](#), the insurer pays all examination expenses that exceed the costs and fees necessary to examine an insurer with its principal place of business and home office in this state including, without limitation, actual travel expenses, reasonable living expense allowance, and compensation of employees, agents and contractors of the department, as determined and approved by the director.

History.

1961, ch. 330, § 607, p. 645; am. 1981, ch. 174, § 1, p. 306; am. 2016, ch. 92, § 2, p. 282.

STATUTORY NOTES

Amendments.

The 2016 amendment, by ch. 92, added the exception at the beginning of subsection (1); added paragraph (2)(c); and added subsection (5).

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2840. Vouchers for expenditures. — (1) No insurer shall make any disbursement of twenty-five dollars (\$25) or more, unless evidenced by a voucher or other document correctly describing the consideration for the payment and supported by a check or receipt endorsed or signed by or on behalf of the person receiving the money.

(2) If the disbursement is for services and reimbursement, the voucher or other document, or some other writing referred to therein, shall describe the services and itemize the expenditures.

(3) If the disbursement is in connection with any matter pending before any legislature or public body or before any public official, the voucher or other document shall also correctly describe the nature of the matter and of the insurer's interest therein.

History.

1961, ch. 330, § 608, p. 645.

§ 41-2841. Borrowed surplus. — (1) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest at such rate or rates approved by the director, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess or surplus, as stipulated in the agreement. A commission or promotion expense may be paid in connection with any such loan upon approval of the director.

(2) Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement, or be the basis of any setoff, but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(3) Any such loan shall be subject to the director's approval. The insurer shall, in advance of the loan, file with the director a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within fifteen (15) days after the date of such filing the insurer is notified of the director's disapproval and the reasons therefor. The director shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended, or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

(4) Any such loan to a mutual insurer or substantial portion thereof shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such a loan shall be made by a mutual insurer unless approved in advance by the director.

(5) This section shall not apply to loans obtained by the insurer in ordinary course of business from banks and other financial institutions, nor

to loans secured by pledge or mortgage of assets.

History.

1961, ch. 330, § 609, p. 645; am. 1973, ch. 11, § 1, p. 24; am. 1982, ch. 171, § 1, p. 450; am. 2006, ch. 25, § 1, p. 83.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 25, rewrote the last sentence of subsection (1) which formerly read: “No commission or promotion expense shall be paid in connection with any such loan.”

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2842. Participating policies. — (1) As provided in its articles of incorporation, a domestic stock insurer or domestic mutual insurer may issue any or all of its policies with or without participation in profits, savings, unabsorbed portions of premiums, or surplus; may classify policies issued and risks insured on a participating and nonparticipating basis, and, subject to [section 41-1933\(3\), Idaho Code](#), may determine the right to participate and the extent of participation of any class or classes of policies. Any such classification or determination shall be reasonable.

(2) A life insurer may issue both participating and nonparticipating policies only if the right or absence of right to participate is reasonably related to the premium charged.

(3) No dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy; except, that a participating life or disability insurance policy providing for participation at the end of the first or second policy year may provide that the dividend or dividends will be paid subject to payment of premium for the next ensuing year.

History.

1961, ch. 330, § 610, p. 645; am. 1972, ch. 70, § 1, p. 145.

§ 41-2843. Dividends to stockholders. — A domestic stock insurer shall not pay any dividend to stockholders except out of earned surplus. Prior to payment thereof, the director, in his discretion, may approve the payment of a dividend from other than earned surplus. For purposes of this section, “earned surplus” shall include surplus arising from unrealized capital gains or revaluation of assets.

History.

1961, ch. 330, § 611, p. 645; am. 1993, ch. 194, § 14, p. 492.

STATUTORY NOTES

Compiler’s Notes.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

Section 37 of S.L. 1993, ch. 194 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

CASE NOTES

Decisions Under Prior Law [Basis of taxation.](#)

[Taxable gross income.](#)

Basis of Taxation.

A life insurance company is not an ordinary corporation under the income tax law and, therefore, may be taxed upon a different basis. *John Hancock Mut. Life Ins. Co. v. Haworth*, 68 Idaho 185, 191 P.2d 359 (1948).

Taxable Gross Income.

A life insurance company being limited in its source of revenue, its investment of its revenue, and its obligation to pay the 3% tax on gross premiums received, justified the legislature in limiting its gross income, for income tax purposes, to interest, dividends and rents. *John Hancock Mut. Life Ins. Co. v. Haworth*, 68 Idaho 185, 191 P.2d 359 (1948).

§ 41-2844. Dividends to policy holders. — (1) The directors of a domestic mutual insurer may from time to time apportion any pay or credit to its members dividends only out of that part of its surplus funds which represents net realized savings, net realized earnings, and net realized capital gains, all in excess of the surplus required by law to be maintained by the insurer.

(2) A dividend otherwise proper may be payable out of such savings, earnings, and gains even though the insurer's total surplus is then less than the aggregate of contributed surplus remaining unpaid by the insurer.

(3) A domestic stock insurer may pay dividends to holders of its participating policies out of any available surplus funds.

(4) No dividend shall be paid which is inequitable, or which unfairly discriminates as between classifications of policies or policies within the same classification.

(5) This section is subject to section 41-1933(3)[, Idaho Code] (provision, *etc.* of dividends out of earnings on nonparticipating policies).

History.

1961, ch. 330, § 612, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in subsection (5) was added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

CASE NOTES

Cited *Kelso & Irwin, P.A. v. State Ins. Fund*, 134 Idaho 130, 997 P.2d 591 (2000).

§ 41-2845. Illegal dividends — Penalty. — (1) Any director of a domestic stock insurer or domestic mutual insurer who knowingly votes for or concurs in declaration or payment of a dividend to stockholders or policyholders other than as authorized under sections 41-2843 or 41-2844[, Idaho Code,] shall upon conviction thereof be subject to the penalties provided by section 41-117[, Idaho Code] (general penalty), and shall be jointly and severally liable, together with other such directors likewise voting for or concurring, for any loss thereby sustained by creditors of the insurer to the extent of such dividend.

(2) Any stockholder receiving such an illegal dividend shall be liable in the amount thereof to the insurer.

(3) The director may revoke or suspend the certificate of authority of any insurer which has declared or paid such an illegal dividend.

History.

1961, ch. 330, § 613, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in subsection (1) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2846. Contingent liability of mutual members. — (1) Except as provided otherwise in section 41-2849[, Idaho Code,] with respect to nonassessable policies, each member of a domestic mutual insurer shall have a contingent liability, pro rata and not one for another, for the discharge of its obligations, which contingent liability shall be in such maximum amount as is specified in the insurer's articles of incorporation consistent with section 41-2804(3)(a)(v)[, Idaho Code].

(2) Every policy issued by the insurer shall contain a statement of the contingent liability.

(3) Termination of the policy of any such member shall not relieve the member of contingent liability for his proportion of the obligations of the insurer which accrued while the policy was in force as provided in section 41-2847[, Idaho Code].

(4) Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of its financial condition.

History.

1961, ch. 330, § 614, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in subsections (1) and (3) were added by the compiler to conform to the statutory citation style.

CASE NOTES

Decisions Under Prior Law Minimum Surplus.

Former law which required surplus of \$300,000 as a condition to plaintiff's privilege of writing classes of insurance other than fire, and its right to extinguish the contingent liability of its policy holders and issue nonassessable policies, referred to that amount as a minimum requirement,

thus implying that a reasonable excess thereof is both prudent and desirable.
Snake River Mut. Fire Ins. Co. v. Neill, 80 Idaho 534, 336 P.2d 107 (1959).

§ 41-2847. Levy of contingent liability. — (1) If at any time the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required to be maintained by it under this code for authority to transact the kinds of insurance being transacted, and the deficiency is not cured from other sources, its directors may, if the same is approved by the director, levy an assessment only on its members who held the policies providing for contingent liability at any time within the twelve (12) months next preceding the date the levy was authorized by the board of directors, and such members shall be liable to the insurer for the amount so assessed.

(2) The levy of assessment shall be for such an amount, subject to the director's approval, as is required to cure such deficiency and to provide a reasonable amount of working funds above such minimum amount of surplus, but such working funds so provided shall not exceed five per cent (5%) of the sum of the insurer's liabilities and such minimum required surplus as of the date of the levy.

(3) As to the respective policies subject to the levy, the assessment shall be computed upon such reasonable basis as may be approved by the director in writing in advance of the levy.

(4) No member shall have an offset against any assessment for which he is liable, on account of any claim for unearned premium or loss payable.

(5) As to life insurance, any part of such assessment upon a member which remains unpaid following notice of assessment, demand for payment, and lapse of a reasonable waiting period as specified in such notice, may, if approved by the director as being in the best interests of the insurer and its members, be secured by placing a lien upon the cash surrender values and accumulated dividends held by the insurer to the credit of the member.

History.

1961, ch. 330, § 615, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2848. Enforcement of contingent liability. — (1) The insurer shall notify each member of the amount of the assessment to be paid by written notice mailed to the member's address last of record with the insurer. Failure of the member to receive the notice so mailed, within the time specified therein for the payment of the assessment or at all, shall be no defense in any action to collect the assessment.

(2) If a member fails to pay the assessment within the period specified in the notice, which period shall not be less than twenty (20) days after mailing, the insurer may institute suit to collect the same.

History.

1961, ch. 330, § 616, p. 645.

§ 41-2849. Nonassessable policies — Mutual insurers. — (1) A domestic mutual insurer while maintaining unimpaired surplus funds not less in amount than the minimum paid-in capital stock required of a domestic stock insurer formed under this code for authority to transact the same kind or kinds of insurance, may, upon receipt of the director's order so authorizing, extinguish the contingent liability to assessment of its members as to all its policies in force and may omit provisions imposing contingent liability in all policies currently issued.

(2) The director shall not authorize a domestic insurer to extinguish the contingent liability of any of its members or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its members and in all such policies for all kinds of insurance transacted by it.

(3) A foreign or alien mutual insurer may issue nonassessable policies to its members in this state pursuant to its charter and the laws of its domicile.

History.

1961, ch. 330, § 617, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Cited *Kelso & Irwin, P.A. v. State Ins. Fund*, 134 Idaho 130, 997 P.2d 591 (2000).

§ 41-2850. Nonassessable policies — Revocation of authority. — (1)

The director shall revoke the authority of a domestic mutual insurer to issue policies without contingent liability if

(a) At any time the insurer's assets are less than the sum of its liabilities and the surplus required for such authority, or (b) The insurer, by resolution of its board of directors approved by a majority of its members, requests that the authority be revoked.

(2) During the absence of such authority the insurer shall not issue any policy without providing therein for the contingent liability of the policyholder, nor renew any policy which is then in force without endorsing the same to provide for such contingent liability.

History.

1961, ch. 330, § 618, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2851. Solicitations in other states. — (1) No domestic insurer shall knowingly solicit insurance business in any reciprocating state in which it is not then licensed as an authorized insurer.

(2) This section shall not prohibit advertising through publications and radio, television and other broadcasts originating outside such reciprocating state, if the insurer is licensed in a majority of the states in which such advertising is disseminated, and if such advertising is not specifically directed to residents of such reciprocating state.

(3) This section shall not prohibit insurance, covering persons or risks located in a reciprocating state, under contracts solicited and issued in states in which the insurer is then licensed. Nor shall it prohibit insurance effectuated by the insurer as an unauthorized insurer in accordance with the laws of the reciprocating state.

(4) A “reciprocating” state, as used herein, is one under the laws of which a similar prohibition is imposed upon and enforced against insurers domiciled in that state.

(5) The director shall suspend or revoke the certificate of authority of a domestic insurer found by him, after a hearing, to have violated this section.

History.

1961, ch. 330, § 619, p. 645.

STATUTORY NOTES

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2852. Impairment of capital or assets. — (1) If the assets of a domestic insurer are less than its liabilities and the minimum amount of capital funds required to be maintained by it under [section 41-313, Idaho Code](#), for authority to transact the kinds of insurance being transacted, the director shall at once determine the amount of deficiency and serve notice upon the insurer to cure the deficiency and file proof thereof with him within the period specified in the notice, which period shall be not less than thirty (30) nor more than ninety (90) days from the date of the notice. Such notice may be so served by delivery to the insurer, or by mailing to the insurer addressed to its registered office in this state.

(2) The deficiency may be made good in cash or in assets eligible under chapter 7[, title 41, Idaho Code] (investments) for the investment of the insurer's funds; or by amendment of the insurer's certificate of authority to cover only such kind or kinds of insurance thereafter for which the insurer has sufficient paid-in capital stock (if a stock insurer) or surplus (if a mutual insurer) under this code; or, if a stock insurer, by reduction of the number of shares of the insurer's authorized capital stock or the par value thereof through amendment of its articles of incorporation, to an amount of authorized and paid-in capital stock not below the minimum required for the kinds of insurance thereafter to be transacted.

(3) After any such reduction of authorized capital stock the insurer shall require the surrender to it of outstanding stock certificates in exchange for new certificates to be issued in lieu thereof for such number and/or par value of shares as the respective stockholders are proportionately entitled to receive.

(4) If the deficiency is not made good and proof thereof filed with the director within the period required by the notice as specified in subsection (1) above, the insurer shall be deemed insolvent and the director shall institute delinquency proceedings against it under chapter 33[, title 41, Idaho Code] of this code.

History.

1961, ch. 330, § 620, p. 645; am. 1999, ch. 65, § 7, p. 168.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions near the beginning of subsection (2) and near the end of subsection (4) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2853. Assessment of stockholders or members. — (1) Any insurer receiving the director's notice required in section 41-2852(1)[, Idaho Code]:

(a) If a stock insurer and to the extent that stockholders are subject to assessment under the insurer's articles of incorporation, by resolution of its board of directors the insurer may assess its stockholders for amounts necessary to cure the deficiency and provide the insurer with a reasonable amount of surplus in addition. If any stockholder fails to pay a lawful assessment after notice given to him in person, or by mail addressed to him at his address last of record with the insurer, or in such other manner as may be approved by the director, the insurer may require the return of the certificates of stock theretofore held by the stockholder, and in cancellation and in lieu thereof issue new certificates for such number of shares as the stockholder may then be entitled to, upon the basis of the stockholder's proportionate interest in the amount of the insurer's capital stock as determined by the director to be remaining unimpaired at the time of the determination of the amount of impairment under section 41-2852[, Idaho Code], after deducting from such proportionate interest the amount of such unpaid assessment. The insurer may pay for or issue fractional shares under this subsection.

(b) If a mutual insurer, may levy an assessment upon members as is provided for under section 41-2847[, Idaho Code].

(2) Neither this section nor section 41-2852[, Idaho Code] shall be deemed to prohibit the insurer from curing any such deficiency through any lawful means other than those referred to in such sections.

History.

1961, ch. 330, § 621, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions throughout the section were added by the compiler to conform to the statutory citation style.

§ 41-2854. Mutualization of stock insurers. — (1) A stock insurer other than a title insurer may become a mutual insurer under such plan and procedure as may be approved by the director after a hearing thereon.

(2) The director shall not approve any such plan, procedure or mutualization unless:

- (a) It is equitable to stockholders and policyholders;
- (b) It is subject to approval by the holders of not less than a majority of the insurer's outstanding capital stock having voting rights, and by not less than a majority of the insurer's policyholders who vote on such plan in person, by proxy or by mail pursuant to such notice and procedure as may be approved by the director;
- (c) If a life insurer, the right to vote thereon is limited to holders of policies other than term or group policies, and whose policies have been in force for more than one (1) year;
- (d) Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair market value thereof as determined by competent disinterested appraisers;
- (e) The plan provides for the purchase of the shares of any nonconsenting stockholder in the same manner and subject to the same applicable conditions as provided by the general corporation law of the state as to rights of nonconsenting stockholders, with respect to consolidation or merger of private corporations;
- (f) The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective; and
- (g) The mutualization leaves the insurer with surplus funds reasonably adequate for the security of its policyholders and to enable it to continue successfully in business in the states in which it is then authorized to transact insurance, and for the kinds of insurance included in its certificates of authority in such states.

(3) No director, officer, agent or employee of the insurer, nor any other person, shall receive any fee, commission or other valuable consideration whatsoever for in any manner aiding, promoting, or assisting therein except as set forth in the plan of mutualization as approved by the director.

(4) This section shall not apply to mutualization under order of court pursuant to rehabilitation or reorganization of an insurer under chapter 33[, title 41, Idaho Code].

History.

1961, ch. 330, § 622, p. 645.

STATUTORY NOTES

Cross References.

For general corporation law see § 30-21-101 et seq.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of subsection (4) was added by the compiler to conform to the statutory citation style.

§ 41-2854A. Mutualization of service corporations. — (1) Every corporation organized or existing under chapter 34, title 41, Idaho Code, as a hospital service corporation, a combined professional service and hospital service corporation, or a professional service corporation whose articles of incorporation specify participant licensee services are to be provided by physicians or surgeons, of either medicine and surgery or of osteopathic medicine and surgery, shall file with the director of the department of insurance a plan of mutualization on or before January 1, 1995. Any other corporation organized under chapter 34, title 41, Idaho Code, may at any time file a plan of mutualization. Any corporation organized under chapter 34, title 41, Idaho Code, may hereafter be referred to in this section as a “service corporation.” The director of the department of insurance shall approve any plan of mutualization so filed, and forthwith issue a certificate of authority to the filing corporation to transact insurance in this state pursuant thereto, if:

- (a) Except as herein provided and except as consistent with or implicit in the conversion of the service corporation to a mutual insurer, the plan does not deprive existing corporate members of statutory rights expressly set forth in chapter 34, title 41, Idaho Code;
- (b) The plan has been approved by the corporation’s board of directors;
- (c) The corporation satisfies the minimum surplus or deposit requirements of this title for the type or types of mutual insurer to which it will convert, as specified by the corporation in its plan; and
- (d) The plan requires the corporation to honor subscribers’ existing contractual rights in their subscriber agreements as if the corporation had not been converted to a mutual insurer. Approval by the service corporation’s board of directors of the plan of mutualization shall be sufficient and effective without the approval or vote of the service corporation’s members, notwithstanding any other provision of law to the contrary or of the service corporation’s bylaws or articles of incorporation. The filing of such a board-approved plan, together with the issuance by the director of the department of insurance of a certificate of authority, shall constitute legal authority, effective from and after the

effective date of the plan, specified in the plan, for the corporation to transact insurance in Idaho as a nonprofit mutual insurer pursuant to such plan.

(2) A plan of mutualization shall provide that, from and after its effective date, the corporation's reserves shall not be used for any purpose or distributed in any manner contrary to this title. A plan of mutualization shall also provide for a "transition period" commencing with the plan's effective date and ending with a date identified as the "transition period termination date," which shall be a date not later than the first anniversary of the effective date of such plan. Prior to the expiration of the transition period, the corporation's reserves shall not be used for any purpose or distributed in any manner contrary to [section 41-3421, Idaho Code](#). Following conversion, the corporation shall continue to be a nonprofit corporation; provided however, the board of directors of a mutualized service corporation may from time to time declare, apportion, and pay or credit to the corporation's members dividends pursuant to this title if the corporation's articles of incorporation (as amended, if applicable, in conjunction with the filing or after the effective date of its plan of mutualization) expressly so provide. Notwithstanding any other provision of law to the contrary, no corporation (including by way of illustration and not limitation, any direct or indirect successor corporation or entity, by merger or acquisition of substantially all its assets) mutualizing under this section shall, in the event of its dissolution, distribute any of its assets except as provided by its articles of incorporation in effect immediately before the effective date of its plan of mutualization; nor shall any such corporation take or fail to take any action that would prevent it from making such distributions at the time of its dissolution.

(3) From and after the transition period termination date, the obligations of participant hospitals, participant physicians, and other licensees under sections 41-3415, 41-3415A, 41-3416 and 41-3431, Idaho Code, and all voting rights held by participant hospitals, participant physicians, and any other participant licensees by virtue of participant status under chapter 34, title 41, Idaho Code, shall be extinguished, but until such transition period termination date, they shall retain such voting rights and obligations as they held and for which they were accountable prior to mutualization hereunder, including duties and responsibilities to the corporation and its subscribers.

Each policyholder of a policy issued on or after such plan's effective date shall have all the rights and liabilities of a member of a mutual insurer under the policy, under the corporation's articles of incorporation and bylaws, and as provided by law. Before such transition period termination date, the corporation shall replace, convert by agreement with subscribers, or allow to lapse pursuant to their express terms all subscriber agreements, so that from and after such transition period termination date the corporation shall have no subscriber agreements in force. From and after the effective date of its plan of mutualization, the corporation shall issue no subscriber agreements, but shall be authorized to accept applications for and to issue insurance policies of the kind or kinds specified by the plan and the corporation is qualified to issue pursuant to law.

(4) The service corporation shall file with the director of the department of insurance, as part of its plan of mutualization, amended bylaws and articles of amendment to articles of incorporation, approved by its board of directors, which articles and bylaws shall conform in all respects with the requirements of this chapter and any applicable rules duly promulgated hereunder, and shall become effective on the effective date of such plan. Approval by the service corporation's board of directors of such amendments to its articles and bylaws shall be sufficient and effective without the approval or vote of the corporation's members, notwithstanding any contrary provision of law or of the service corporation's bylaws or articles of incorporation. Pursuant to the Idaho nonprofit corporation act, the service corporation shall also file with the Idaho secretary of state articles of amendment to its articles of incorporation.

(5) For the period ending on the transition period termination date, the corporation's plan of mutualization and its articles of incorporation and bylaws may contain provisions the corporation's board of directors, in the exercise of its discretion and in fulfillment of its duties, deems necessary, convenient or prudent to implement the plan of mutualization, including, but not limited to, transition provisions, expressly identified as such, that allocate voting power among policyholder members, participant licensees and participant hospitals, as applicable and as the board of directors may deem reasonably appropriate; provided however, all transition provisions, whether in the corporation's articles of incorporation, bylaws or plan of

mutualization, shall, without further action or filing, expire upon the transition period termination date.

(6) Within forty-two (42) days of the filing date of a corporation's plan of mutualization, the director shall approve the same and issue a certificate of authority to the corporation unless the director finds such plan does not comply with subsection (1) of this section, in which case the director shall within such forty-two (42) day period issue a written order disapproving such plan and specifying the reasons therefor. The corporation may preserve the legal effectiveness and effective date of its plan by curing or otherwise responsibly addressing each asserted deficiency identified by the director and filing within fourteen (14) days of the effective date of the director's order an amended plan of mutualization that reflects corrections and responses made. Within fourteen (14) days of such filing, the director shall issue a certificate of authority or a final order disapproving such amended plan and specifying the reasons therefor, which final order may, within forty-two (42) days after its effective date, be appealed to the district court for Ada county, state of Idaho. Notwithstanding the director's final order, the corporation shall be legally authorized to transact business pursuant to its plan of mutualization until the forty-second day following the latest of:

- (a) The effective date of the director's final order;
- (b) The entry of final judgment by the district court in which review of the director's final order has been sought; and
- (c) The director's compliance and the district court's compliance (by entry of a final judgment) with the opinion issued by the last appellate court to which appeal may be taken that has reviewed the district court's judgment concerning the director's final order. If the director has prevailed upon final judgment being entered, the corporation's legal authority to transact business pursuant to its plan of mutualization shall expire at the end of such period; however, if the corporation has prevailed or corrected all deficiencies identified in the director's final order, the director shall, before or upon the expiration of such period, issue a certificate of authority to the corporation. Issuance of a certificate of authority under this section shall not preclude the director from commencing any proceedings for alleged violations of this title. The

procedure in this subsection shall apply to corporations existing under chapter 34, title 41, Idaho Code, on December 31, 1993.

(7) [Section 41-2805, Idaho Code](#), and any other provision of this title dealing with newly organized mutual insurers as such, shall have no application to a plan of mutualization under this section or to the corporation adopting or implementing such plan.

(8) If, pursuant to [section 41-3406, Idaho Code](#), a mutualizing service corporation is also operating as a health maintenance organization immediately prior to the effective date of its plan of mutualization, it shall be legally authorized to continue such operations in the manner provided for in said plan after the effective date thereof as if such service corporation had not become a mutual insurer under this section.

(9) From and after the effective date of a plan of mutualization, a corporation mutualizing under this section shall be liable for the tax imposed and provided for in [section 41-402, Idaho Code](#), but only with respect to insurance policies (as opposed to subscriber agreements) issued by it, and subject to refunds, reductions and other adjustments applicable to other domestic mutual insurers. Until all subscriber agreements are terminated, expire or are otherwise converted to policies of insurance issued by the corporation as a mutual insurer, the corporation shall continue to be liable for and pay the tax on subscriber contracts in the manner provided in [section 41-3427, Idaho Code](#), subject to the same exemptions provided in that section, except for premium taxes paid pursuant to this subsection on policies issued as a mutual insurer.

(10) Except as modified in this section and other applicable law, after the effective date of a service corporation's plan of mutualization, all contracts, rights, powers, privileges, liabilities and obligations of such corporation shall continue unchanged and in effect until repealed, terminated, canceled, amended, waived, satisfied or otherwise legally extinguished.

History.

[I.C., § 41-2854A](#), as added by 1994, ch. 78, § 1, p. 173; am. 2003, ch. 103, § 5, p. 323.

STATUTORY NOTES

Cross References.

Nonprofit corporations, § 30-30-101 et seq.

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 7 of S.L. 1994, ch. 78 provided: "An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2 and 7 of this act shall be in full force and effect on and after passage and approval, and Sections 3, 4, 5 and 6 of this act shall be in full force and effect on and after January 1, 1995."

§ 41-2855. Conversion of mutual insurer to stock insurer. — (1) A mutual insurer may become a stock insurer under such plan and procedure as may be approved by the director after a hearing thereon.

(2) The director shall not approve any conversion plan or procedure unless:

(a) It is equitable to the insurer's members;

(b) It is subject to approval by vote of not less than a majority of the insurer's current members voting thereon in person, by proxy, or by mail at a meeting of members called for the purpose pursuant to such reasonable notice and procedure as may be approved by the director. If a life insurer, the right to vote may be limited to members who hold policies other than term or group policies and whose policies have been in force for not less than one (1) year;

(c) The equity of each policyholder in the insurer is determinable under a fair formula approved by the director, which equity shall be based upon not less than the insurer's entire surplus, after deducting contributed or borrowed surplus funds, plus a reasonable present equity in its reserves and in all nonadmitted assets;

(d) The policyholders entitled to participate in the purchase of stock or distribution of assets shall include all current policyholders and all existing persons who had been policyholders of the insurer within three (3) years prior to the date such plan was submitted to the director;

(e) The plan gives to each policyholder of the insurer, as specified in paragraph (d) of this subsection, a preemptive right to acquire his proportionate part of all of the proposed capital stock of the insurer within a designated reasonable period, and to apply upon the purchase thereof the amount of his equity in the insurer as determined under paragraph (c) of this subsection;

(f) Shares are so offered to policyholders at a price not greater than to be thereafter offered to others but at not more than double the par value of such shares;

(g) The plan provides for payment of cash in the amount of not less than fifty percent (50%) of the amount of the policyholder's equity not so used for the purchase of stock to each policyholder not electing to exercise his preemptive right to apply his equity in the insurer toward the purchase of capital stock as provided in paragraph (e) of this subsection. The cash payment together with stock so purchased, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of such mutual insurer;

(h) The plan, when completed, would provide for the converted insurer paid-up capital stock and additional surplus in amounts not less than the minimum paid-up capital and surplus required of a domestic stock insurer transacting like kinds of insurance, as provided in [section 41-313, Idaho Code](#); and

(i) It contains additional provisions or standards as the director may reasonably require.

(3) No director, officer, agent or employee of the insurer, nor any other person, shall receive any fee, commission or other valuable consideration whatsoever for aiding, promoting, or assisting therein except as set forth in the plan as approved by the director.

(4) Except as otherwise specifically provided in subsection (5) of this section, prior to and for a period of five (5) years following the director's approval of a new stock insurer under subsection (2) of this section, no person other than the new stock insurer shall, without the prior approval of the director, directly or indirectly offer to acquire or acquire in any manner the beneficial ownership of five percent (5%) or more of any class of a voting security of the new stock insurer or of any institution which owns a majority or all of the voting securities of the stock insurer.

(5) Nothing in this section shall prohibit the inclusion in the plan of conversion of provisions under which individuals comprising the new stock insurer's board of directors, officers, employees, agents, and persons acting as trustees of employee stock ownership plans or other employee benefit plans may be entitled to purchase for cash capital stock of the new stock insurer at the same price initially issued by the new stock insurer under the plan of conversion. Nothing in this section shall prohibit a management-incentive compensation program which is contained in the plan of

conversion and approved by the director to be adopted upon conversion to the new stock insurer or prohibit such a program to be later adopted by the new stock insurer.

History.

I.C., § 41-2855, as added by 1990, ch. 284, § 2, p. 794; am. 1998, ch. 304, § 1, p. 1004.

STATUTORY NOTES

Prior Laws.

Former § 41-2855, which comprised 1961, ch. 330, § 623, p. 645, was repealed by S.L. 1990, ch. 284, § 1.

§ 41-2856. Mergers and consolidations of stock insurers. — (1) A domestic stock insurer may merge or consolidate with one or more domestic or foreign stock insurers, or ordinary business corporations having as their principal assets, cash or assets of a character allowed by investment by domestic insurers pursuant to the provisions of chapter 7, title 41, Idaho Code, provided the surviving corporation shall be a domestic or foreign stock insurer, by complying with the applicable provisions of the statutes of this state governing the merger or consolidation of stock corporations formed for profit, but subject to subsections (2), (3) and (4) below.

(2) The agreement and plan of merger may provide for the restatement of the capital and surplus accounts of the surviving corporation, constituting all surplus in excess of stated capital, borrowed surplus and allowance for non-admitted assets, if any, as unassigned surplus, thereby increasing or decreasing the stated capital or gross paid in and contributed surplus accounts of the constituent corporations and providing additional surplus in any forms specified in the agreement and plan of merger; provided any reorganization of capital or surplus account must be indicated on the annual financial statement.

(3) No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the director and approved in writing by him after a hearing thereon after notice to the stockholders of each insurer involved. The director shall give such approval within a reasonable time after such filing unless he finds such plan or agreement:

- (a) Is contrary to law; or
- (b) Inequitable to the stockholders of any insurer involved; or
- (c) Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state or elsewhere; or
- (d) Is subject to other material and reasonable objections.

(4) No director, officer, agent or employee of any insurer party to such merger or consolidation shall receive any fee, commission, compensation or

other valuable consideration whatsoever for in any manner aiding, promoting or assisting therein except as set forth in such plan or agreement.

(5) If the director does not approve any such plan or agreement he shall so notify the insurer in writing specifying his reasons therefor.

(6) Any plan or proposal through which a stock insurer proposes to acquire a controlling stock interest in another stock insurer through an exchange of stock of the first insurer, issued by the insurer for the purpose, for such controlling stock of the second insurer is deemed to be a plan or proposal of merger of the second insurer into the first insurer for the purposes of this section and is subject to the applicable provisions hereof.

(7) Reinsurance of all or substantially all of the insurance in force of an insurer by another insurer, shall also be subject to the provisions of this section as if a merger.

History.

1961, ch. 330, § 624, p. 645; am. 1971, ch. 122, § 12, p. 408.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2857. Mergers and consolidations of mutual insurers. — (1) Except as set forth in [section 41-3824, Idaho Code](#), a domestic mutual insurer shall not merge or consolidate with a stock insurer.

(2) A domestic mutual insurer may merge or consolidate with another mutual insurer under the applicable procedures prescribed by the statutes of this state applying to corporations formed for profit, except as hereinbelow provided.

(3) The plan and agreement for merger or consolidation shall be submitted to and approved by at least two-thirds (2/3) of the members of each mutual insurer voting thereon at meetings called for the purpose pursuant to such reasonable notice and procedure as has been approved by the director. If a life insurer, right to vote may be limited to members whose policies are other than term and group policies and have been in effect for more than one (1) year.

(4) No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the director and approved by him in writing after a hearing thereon. The director shall give such approval within a reasonable time after such filing unless he finds such plan or agreement:

- (a) Inequitable to the policyholders of any domestic insurer involved; or
- (b) Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state and elsewhere; or
- (c) Is subject to other material and reasonable objections.

(5) If the director does not approve such plan or agreement, he shall so notify the insurers in writing specifying his reasons therefor.

(6) No director, officer, agent or employee of any insurer party to such merger or consolidation, nor any other person, shall receive any fee, commission or other valuable consideration whatsoever for in any manner aiding, promoting, or assisting therein except as set forth in the plan and agreement approved by the director.

History.

1961, ch. 330, § 625, p. 645; am. 1998, ch. 303, § 2, p. 1001; am. 2013, ch. 266, § 11, p. 652.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 266, updated the reference in subsection (1) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2858. Bulk reinsurance — Mutual insurers. — (1) A domestic mutual insurer may reinsure all or substantially all of its business in force, or all or substantially all of a major class thereof, with another insurer, stock or mutual, by an agreement of bulk reinsurance after compliance with this section. No such agreement shall become effective unless filed with the director and approved by him in writing.

(2) The director shall approve such agreement within a reasonable time after filing if he finds it to be fair and equitable to each domestic insurer involved, and that such reinsurance if effectuated would not substantially reduce the protection or service to its policyholders. If the director does not so approve, he shall so notify each insurer involved in writing specifying his reasons therefor.

(3) If for reinsurance of all or substantially all of its business in force, the plan and agreement for such reinsurance must be approved by vote of not less than two-thirds (2/3) of each domestic mutual insurer's members voting thereon at meetings of members called for the purpose, pursuant to such reasonable notice and procedure as the director may approve. If a life insurer, right to vote may be limited to members whose policies are other than term or group policies, and have been in effect for more than one (1) year.

(4) If for reinsurance in a stock insurer of all or substantially all of the insurance in force of a mutual insurer, the agreement must provide for payment in cash to each member of the insurer entitled thereto of his equity, if any, in the business reinsured as determined under a fair formula approved by the director, as based upon the reserves, assets (whether or not "admitted" assets) and surplus, if any, of the mutual insurer to be taken over by the stock insurer.

(5) No director, officer, agent or employee of any insurer party to such reinsurance, nor any other person, shall receive any fee, commission or other valuable consideration whatsoever for in any manner aiding, promoting, or assisting therein except as set forth in the reinsurance agreement.

History.

1961, ch. 330, § 626, p. 645.

STATUTORY NOTES**Compiler's Notes.**

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2859. Mutual member's share of assets on liquidation. — (1) Upon any liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, and expenses of administration, shall be distributed to currently existing persons who had been members of the insurer for at least one year and who were its members at any time within thirty-six (36) months next preceding the date such liquidation was authorized or ordered, or date of last termination of the insurer's certificate of authority whichever date is the earlier; except, that if the director has reason to believe that those in charge of the management of the insurer have caused or encouraged the reduction of the number of members of the insurer in anticipation of liquidation and for the purpose of reducing thereby the number of persons who may be entitled to share in distribution of the insurer's assets, he may enlarge the thirty-six (36) month qualification period above provided for by such additional period as he may deem to be reasonable.

(2) The insurer shall make a reasonable classification of its policies so held by such members, and a formula based upon such classification for determining the equitable distributive share of each such member. Such classification and formula shall be subject to the approval of the director.

History.

1961, ch. 330, § 627, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2860. Equity securities of domestic stock insurance companies — Statements of ownership. — Every person who is directly or indirectly the beneficial owner of more than ten per cent (10%) of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such company, shall file in the office of the director of the department of insurance on or before the 1st day of July, 1965, or within ten (10) days after he becomes such beneficial owner, director or officer, a statement, in such form as the director of the department of insurance may prescribe, of the amount of all equity securities of such company of which he is the beneficial owner, and within ten (10) days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the director of the department of insurance a statement, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

History.

1965, ch. 294, § 1, p. 782.

STATUTORY NOTES

Compiler's Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2861. Recovery of profits resulting from unfair use of information. — For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six (6) months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six (6) months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within sixty (60) days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two (2) years after the date such profit was realized. This section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the director of the department of insurance by rules and regulations may exempt as not comprehended within the purpose of this section.

History.

1965, ch. 294, § 2, p. 782.

STATUTORY NOTES

Compiler's Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2862. Restrictions on sale of equity securities. — It shall be unlawful for any such beneficial owner, director or officer, directly or indirectly, to sell any equity security of such company if the person selling the security or his principal:

(a) does not own the security sold; or

(b) if owning the security, does not deliver it against such sale within twenty (20) days thereafter, or does not within five (5) days after such sale deposit in the mails or other usual channels of transportation; but no person shall be deemed to have violated this section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

History.

1965, ch. 294, § 3, p. 782.

§ 41-2863. Purchases and sales which are exempt. — The provisions of section 41-2861[, Idaho Code,] shall not apply to any purchase and sale, or sale and purchase, and the provisions of section 41-2862[, Idaho Code,] shall not apply to any sale of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The director of the department of insurance may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

History.

1965, ch. 294, § 4, p. 782.

STATUTORY NOTES

Federal References.

The Securities Exchange Act of 1934 is codified as [15 USCS § 78a et seq.](#)

Compiler's Notes.

The bracketed insertions in the first sentence were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2864. Foreign or domestic arbitration transactions exempt. — The provisions of sections 41-2860 — 41-2862[, Idaho Code,] shall not apply to foreign or domestic arbitration transactions unless made in contravention of such rules and regulations as the director of the department of insurance may adopt in order to carry out the purposes of this act.

History.

1965, ch. 294, § 5, p. 782.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the beginning of the section was added by the compiler to conform to the statutory citation style.

The term “this act” at the end of the section refers to S.L. 1965, Chapter 294, which is compiled as §§ 41-2860 to 41-2867.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2865. “Equity security” defined. — The term “equity security” when used in this act means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the director of the department of insurance shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

History.

1965, ch. 294, § 6, p. 782.

STATUTORY NOTES

Compiler’s Notes.

The term “this act” near the beginning of this section refers to S.L. 1965, Chapter 294, which is compiled as §§ 41-2860 to 41-2867.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2866. Conditions exempting equity securities. — The provisions of sections 41-2860 — 41-2862[, Idaho Code,] shall not apply to equity securities of a domestic stock insurance company if:

(a) Such securities shall be registered, or shall be required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934, as amended; or (b) Such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred (100) or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of sections 41-2860 — 41-2862[, Idaho Code,] except for the provisions of this subsection (b).

History.

1965, ch. 294, § 7, p. 782.

STATUTORY NOTES

Federal References.

Section 12 of Securities Exchange Act of 1934, referred to in this section, is compiled as [15 U.S.C.S. § 781](#).

Compiler's Notes.

The bracketed insertions in the introductory paragraph and near the end of subsection (b) were added by the compiler to conform to the statutory citation style.

§ 41-2867. Rules and regulations. — The director of the department of insurance shall have the power to make such rules and regulations as may be necessary for the execution of the functions invested in him by sections 41-2860 — 41-2862[, Idaho Code], and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of sections 41-2860 — 41-2862[, Idaho Code,] imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the director of the department of insurance, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

History.

1965, ch. 294, § 8, p. 782.

STATUTORY NOTES

Compiler's Notes.

The name of the commissioner of insurance has been changed to the director of the department of insurance on the authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions were added by the compiler to conform to the statutory citation style.

Effective Dates.

Section 9 of S.L. 1965, ch. 294 declared an emergency. Approved March 29, 1965.

§ 41-2868. Proxy regulations. — (1) This section shall apply to all domestic stock insurers except:

(a) A domestic stock insurer having less than one hundred (100) stockholders; except, that if ninety-five per cent (95%) or more of the insurer's stock is owned or controlled by a parent or affiliated insurer, this section shall not apply to such insurer unless its remaining shares are held by five hundred (500) or more stockholders.

(b) Domestic stock insurers which, relative to the voting and other securities involved, file with the securities and exchange commission forms of proxies, consents and authorizations pursuant to the Securities Exchange Act of 1934, as amended.

(2) Every insurer to which this section is applicable shall furnish its stockholders in advance of stockholder meetings, information in writing reasonably adequate to inform them relative to all matters to be presented by the insurer's management for consideration of stockholders at such meeting.

(3) No person shall solicit a proxy, consent, or authorization in respect of any stock or other voting security of such an insurer unless he furnishes the person so solicited with written information reasonably adequate as to:

(a) The material matters in regard to which the powers so solicited are proposed to be used; and

(b) The person or persons on whose behalf the solicitation is made, and the interest of such person or persons in relation to such matters.

(4) No person shall so furnish to another, information which the informer knows or has reason to believe is false or misleading as to any material fact, or which fails to state any material fact reasonably necessary to prevent any other statement made from being misleading.

(5) The form of all such proxies shall:

(a) Conspicuously state on whose behalf the proxy is solicited;

(b) Provide for dating the proxy;

- (c) Impartially identify each matter or group of related matters intended to be acted upon;
- (d) Provide means for the principal to instruct the vote of his shares as to approval or disapproval of each matter or group, other than election to office; and
- (e) Be legibly printed, with context suitably organized.

Except, that a proxy may confer discretionary authority as to matters as to which choice is not specified pursuant to item (d), above, if the form conspicuously states how it is intended to vote the proxy or authorization in each such case; and may confer discretionary authority as to other matters which may come before the meeting but unknown for a reasonable time prior to the solicitation by the persons on whose behalf the solicitation is made.

(6) No proxy shall confer authority (a) to vote for election of any person to any office for which a bona fide nominee is not named in the proxy statement, or (b) to vote in any annual meeting (or adjournment thereof) other than the annual meeting next following the date on which the proxy statement and form were furnished stockholders.

(7) The director shall have authority to make and promulgate reasonable rules and regulations for the effectuation of this section, and in so doing shall give due consideration to rules and regulations promulgated for similar purposes by the insurance supervisory officials of other states.

(8) Any proxy, consent or authorization obtained in violation of this section or of the lawful rules and regulations of the director hereunder, shall be void.

History.

I.C., § 41-2868, as added by 1969, ch. 214, § 68, p. 625.

STATUTORY NOTES

Federal References.

The Securities Exchange Act of 1934, referred to in paragraph (1)(b), is codified as 15 USCS § 78a et seq.

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2869. Purpose. — The purpose of sections 41-2870 through 41-2871, 41-2839(4)(c), and 41-804(3), Idaho Code, is to authorize insurance companies to utilize modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate regulations by the director of the department of insurance for safeguarding the assets and facilitating the director's examination of the insurance company's financial condition.

History.

I.C., § 41-2869, as added by 1981, ch. 174, § 2, p. 306.

§ 41-2870. Definitions. — As used in this act:

(1) “Securities” mean instruments as defined in section 28-8-102(1)(a) [28-8-102(1)(o)], Idaho Code.

(2) “Clearing corporation” means a corporation as defined in section 28-8-102(3) [28-8-102(1)(e)], Idaho Code.

(3) “Direct participant” means a national bank, state bank or trust company which maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(4) “Federal reserve book-entry system” means the computerized systems sponsored by the United States department of the treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and such agencies and instrumentalities, respectively, in federal reserve banks through banks which are members of the federal reserve system.

(5) “Member bank” means a national bank, state bank or trust company which is a member of the federal reserve system and to which an insurance company participates in the federal reserve book entry system.

History.

I.C., § 41-2870, as added by 1981, ch. 174, § 2, p. 306.

STATUTORY NOTES

Compiler’s Notes.

The term “this act” in the introductory paragraph refers to S.L. 1981, Chapter 174, which is compiled as §§ 41-804, 41-2839, and 41-2869 to 41-2871.

The bracketed insertions in subsections (1) and (2) were added by the compiler to reflect the current provisions in chapter 8, title 28, Idaho Code.

§ 41-2871. Use of book-entry systems. — (1) A domestic insurer may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the federal reserve book-entry system. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any member bank through which an insurer holds securities in the federal reserve book-entry system, and the records of any custodian banks through which an insurer holds securities in a clearing corporation, shall at all times show that such securities are held for such insurer and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation or in the federal reserve book-entry system without, in either case, physical delivery of certificates representing such securities.

(2) The director of the department of insurance is authorized to promulgate rules and regulations governing the deposit by insurers of securities with clearing corporations and in the federal reserve book-entry system.

History.

I.C., § 41-2871, as added by 1981, ch. 174, § 2, p. 306.

§ 41-2872. Health care provider contracts — Grievance procedure.

— (1) Any stock or mutual insurer (hereinafter insurance company) issuing benefits pursuant to the provisions of this chapter shall be ready and willing at all times to enter into health care provider service contracts with all qualified health care providers of the category or categories which are necessary to provide the health care services covered by the insurance company's policy of insurance if such health care providers: are qualified under the laws of the state of Idaho, desire to become participant health care providers of the insurance company, meet the requirements of the insurance company, and practice within the general area served by the insurance company.

(2) Nothing in this section shall preclude an insurance company from refusing to contract with a health care provider who is unqualified or who does not meet the terms and conditions of the participating provider contract of the insurance company or from terminating or refusing to renew the contract of a participating health care provider who is unqualified or who does not comply with, or who refuses to comply with, the terms and conditions of the participating health care provider contract including, but not limited to, practice standards and quality requirements. The contract shall provide for written notice to the participating health care provider setting forth any breach of contract for which the insurance company proposes that the contract be terminated or not renewed and shall provide for a reasonable period of time for the participating health care provider to cure such breach prior to termination or nonrenewal. If the breach has not been cured within such period of time the contract may be terminated or not renewed. Provided however, that if the breach of contract for which the insurance company proposes that the contract be terminated or not renewed is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, the contract may be terminated or not renewed immediately.

(3) Every insurance company issuing benefits pursuant to this chapter shall establish a grievance system for health care providers. Such grievance system shall provide for arbitration according to chapter 9, title 7, Idaho Code, or for such other system which provides reasonable due process

provisions for the resolution of grievances and the protection of the rights of the parties.

(4) Subsections (1) and (2) of this section shall apply to health care provider participation contracts entered into after July 1, 1994.

History.

I.C., § 41-2872, as added by 1994, ch. 275, § 1, p. 853.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-2873. Best price — Most favored nations clause prohibited. —

(1) No stock or mutual insurance company (hereafter, insurance company) may require, as an element of any health care provider participation contract, that any provider agree:

(a) To the unnegotiated adjustment by the insurance company of the provider's contractual reimbursement rate to equal the lowest reimbursement rate the provider has agreed to charge any other payor;

(b) To a requirement that the provider adjust, or enter into negotiations to adjust, his or her charges to the insurance company if the provider agrees to charge another payor lower rates; or

(c) To a requirement that the provider disclose his or her contractual reimbursement rates from other payors.

(2) For the purposes of this section, “provider” means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services in Idaho.

History.

I.C., § 41-2873, as added by 1998, ch. 422, § 2, p. 1334.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

Chapter 29

RECIPROCAL INSURERS

Sec.

- 41-2901. “Reciprocal” insurance defined.
- 41-2902. “Reciprocal insurer” defined.
- 41-2903. Scope of chapter — Existing insurers.
- 41-2904. Insuring powers of reciprocals.
- 41-2905. Name — Suits.
- 41-2906. Surplus funds required.
- 41-2907. Attorney.
- 41-2908. Organization of reciprocal insurer.
- 41-2909. Certificate of authority.
- 41-2910. Power of attorney or joint powers entity.
- 41-2911. Modifications.
- 41-2912. Attorney’s bond.
- 41-2913. Deposit in lieu of bond.
- 41-2914. Action on bond.
- 41-2915. Service of process — Judgment.
- 41-2916. Contributions to insurer.
- 41-2917. Annual statement.
- 41-2918. Financial condition — Method of determining.
- 41-2919. Who may be subscribers.
- 41-2920. Subscribers’ advisory committee.
- 41-2921. Subscribers’ liability.
- 41-2922. Subscribers’ liability on judgment.

41-2923. Assessments.

41-2924. Time limit for assessment.

41-2925. Aggregate liability.

41-2926. Nonassessable policies.

41-2927. Distribution of savings.

41-2928. Subscribers' share in assets.

41-2929. Merger or conversion.

41-2930. Impaired reciprocals.

§ 41-2901. “Reciprocal” insurance defined. — “Reciprocal” insurance is that resulting from an interexchange among persons, known as “subscribers”, of reciprocal agreements of indemnity, the interexchange being effectuated through an “attorney in fact” common to all such persons.

History.

1961, ch. 330, § 628, p. 645.

STATUTORY NOTES

Cross References.

Life and Health Insurance Guaranty Association Act, § 41-4301 et seq.

§ 41-2902. “Reciprocal insurer” defined. — A “reciprocal insurer” means an unincorporated aggregation of subscribers operating individually and collectively through an attorney in fact to provide reciprocal insurance among themselves. When all participants in a reciprocal insurer are political subdivisions of the state of Idaho, such interexchange may be accomplished by a joint exercise of powers agreement pursuant to chapter 23, title 67, Idaho Code.

History.

1961, ch. 330, § 629, p. 645; am. 1996, ch. 245, § 2, p. 775.

§ 41-2903. Scope of chapter — Existing insurers. — (1) All authorized reciprocal insurers shall be governed by those sections of this chapter not expressly made applicable to domestic reciprocals. Political subdivisions of the state of Idaho participating in a reciprocal insurance program shall retain all rights, obligations, and immunities which inure to their respective benefit or duty, without compromise or modification, as otherwise provided by law.

(2) Every reciprocal insurer in its own name as in the case of an individual may purchase, receive, own, hold, lease, mortgage, pledge or encumber, and may by deed of trust or otherwise, manage and sell real estate for the purposes and objects of the reciprocal including, but not limited to, investment for the production of income, or for its accommodation in the convenient transaction of its business. Any contract including, but not limited to, deeds, leases, mortgages, deeds of trust, purchase of sale agreements or any other contract to be executed in the name of the reciprocal insurer, may be executed by the attorney designated by the subscribers of the reciprocal insurer.

(3) Existing authorized reciprocal insurers shall after the effective date of this code comply with the provisions of this chapter, and shall make such amendments to their subscribers' agreement, power of attorney, policies and other documents and accounts and perform such other acts as may be required for such compliance.

History.

1961, ch. 330, § 630, p. 645; am. 1992, ch. 76, § 1, p. 214; am. 1996, ch. 245, § 3, p. 775.

STATUTORY NOTES

Compiler's Notes.

The phrase "the effective date of this code" in subsection (3) refers to the effective date of S.L. 1961, Chapter 330, which was effective January 1, 1962.

Effective Dates.

Section 2 of S.L. 1992, ch. 76 declared an emergency. Approved March 26, 1992.

§ 41-2904. Insuring powers of reciprocals. — (1) A reciprocal insurer may, upon qualifying therefor as provided for by this code, transact any kind or kinds of insurance defined by this code, other than life or title insurances.

(2) Such an insurer may purchase reinsurance, and may grant reinsurance as to any kind of insurance it is authorized to transact direct.

History.

1961, ch. 330, § 631, p. 645.

CASE NOTES

Decisions Under Prior Law Proper Party in Interest.

In an action under the Federal Declaratory Judgment Act by an association which had issued a policy of insurance against loss resulting from the operation of an automobile, as attorney in fact for an interinsurance exchange as authorized by law, the exchange was “a proper party in interest,” but was not “an indispensable party.” *Farmers Underwriters Ass’n v. Wanner*, 30 F. Supp. 358 (D. Idaho 1938).

§ 41-2905. Name — Suits. — A reciprocal insurer shall: (1) Have and use a business name. The name shall include the word “reciprocal,” or “interinsurer,” or “interinsurance,” or “exchange,” or “underwriters,” or “underwriting.”

(2) Sue and be sued in its own name.

History.

1961, ch. 330, § 632, p. 645.

CASE NOTES

Application of section.

Class actions.

Application of Section.

The individual members of a reciprocal insurance exchange do not have capacity to sue or be sued in an original action based upon an obligation claimed for or against the insurance exchange. *Lumbermen’s Underwriting Alliance v. Mobil Oil Corp.*, 612 F. Supp. 1166 (D. Idaho 1985), appeal dismissed, 835 F.2d 1435 (9th Cir. 1987).

Class Actions.

In action arising from damages caused by explosion where claims asserted sounded in both contract and tort, since the members of reciprocal insurer could not bring suit in their individual capacity under the laws of the state because the class action device afforded by federal rules as a procedure allowing the members to bring suit in their individual capacity was not available, and, consequently, there was no diversity of citizenship between insurer and defendants, the claims of insurer had to be dismissed for lack of subject matter jurisdiction. *Lumbermen’s Underwriting Alliance v. Mobil Oil Corp.*, 612 F. Supp. 1166 (D. Idaho 1985), appeal dismissed, 835 F.2d 1435 (9th Cir. 1987).

§ 41-2906. Surplus funds required. — (1) A domestic reciprocal insurer is governed, as to surplus required to be maintained, by section 41-313 or 41-313A, Idaho Code.

(2) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the provisions of this code therefor and possesses and maintains surplus funds as to such additional kinds of insurance as provided in [section 41-313, Idaho Code](#).

(3) A domestic reciprocal insurer holding a valid certificate of authority to transact insurance in this state immediately prior to January 1, 1995, shall have a period of two (2) years from and after January 1, 1995, within which to comply with any increase in surplus requirements.

History.

1961, ch. 330, § 633, p. 645; am. 1969, ch. 214, § 69, p. 625; am. 1979, ch. 318, § 2, p. 853; am. 1995, ch. 96, § 5, p. 273.

§ 41-2907. Attorney. — (1) “Attorney,” as used in this chapter, refers to the attorney in fact of a reciprocal insurer. The attorney may be an individual, firm, joint powers entity, or corporation.

(2) The attorney of a foreign or alien reciprocal insurer, which insurer is duly authorized to transact insurance in this state, shall not, by virtue of discharge of its duties as such attorney with respect to the insurer’s transactions in this state, be thereby deemed to be doing business in this state within the meaning of any laws of this state applying to foreign firms or corporations.

History.

1961, ch. 330, § 634, p. 645; am. 1996, ch. 245, § 4, p. 775.

§ 41-2908. Organization of reciprocal insurer. — (1) Twenty-five (25) or more persons domiciled in this state, or employers in this state having aggregate payrolls of not less than one and one-half million dollars (\$1,500,000) and proposing to transact worker's compensation insurance only, may organize a domestic reciprocal insurer and make application to the director for a certificate of authority to transact insurance. A subscriber that is a corporation, limited liability company or other legal entity recognized by the state of Idaho as a separate entity, shall be considered as one (1) subscriber, regardless of the number of its wholly owned subsidiaries.

(2) The proposed attorney shall fulfill the requirements of and shall execute and file with the director when applying for a certificate of authority, a declaration setting forth:

- (a) The name of the insurer;
- (b) The location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this state;
- (c) The kinds of insurance proposed to be transacted;
- (d) The names and addresses of the original subscribers;
- (e) The designation and appointment of the proposed attorney and a copy of the power of attorney;
- (f) The names and addresses of the officers and directors of the attorney, if a corporation, or its members, if a firm;
- (g) The powers of the subscribers' advisory committee; and the names and terms of office of the members thereof;
- (h) That all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;
- (i) A copy of the subscribers' agreement;
- (j) A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the

insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than six (6) months at an adequate rate theretofore filed with and approved by the director;

(k) A statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required in section 41-313 or 41-313A, Idaho Code, is on hand; and

(l) A copy of each policy, endorsement and application form it then proposes to issue or use.

Such declaration shall be acknowledged by the attorney in the manner required for the acknowledgment of deeds.

History.

1961, ch. 330, § 635, p. 645; am. 1995, ch. 96, § 6, p. 273; am. 2006, ch. 199, § 1, p. 615.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 199, in subsection (1), substituted “worker’s compensation” for “workmen’s compensation” in the first sentence and added the last sentence.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2909. Certificate of authority. — (1) The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

(2) The director may refuse, suspend or revoke the certificate of authority, in addition to other grounds therefor, for failure of the attorney to comply with any provision of this code.

History.

1961, ch. 330, § 636, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2910. Power of attorney or joint powers entity. — (1) The rights and powers of the attorney or designated joint powers entity of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

(2) The power of attorney must set forth:

(a) The powers of the attorney;

(b) That the attorney is empowered to accept service of process on behalf of the insurer and to authorize the director to receive service of process in actions against the insurer upon contracts exchanged;

(c) The general services to be performed by the attorney or joint powers entity;

(d) The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses, to be paid by the insurer; and

(e) Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount which amount shall be not less than one (1) nor more than ten (10) times the premium or premium deposit stated in the policy.

(3) The power of attorney or joint exercise of powers agreement may:

(a) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(b) Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

(c) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(d) Contain other lawful provisions deemed advisable.

(4) The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement shall be used or be effective in this state until approved by the director.

History.

1961, ch. 330, § 637, p. 645; am. 1996, ch. 245, § 5, p. 775.

STATUTORY NOTES**Compiler's Notes.**

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Cited *Lumbermen's Underwriting Alliance v. Mobil Oil Corp.*, 612 F. Supp. 1166 (D. Idaho 1985).

§ 41-2911. Modifications. — Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No such modification shall be effective retroactively, nor as to any insurance contract issued prior thereto.

History.

1961, ch. 330, § 638, p. 645.

§ 41-2912. Attorney's bond. — (1) Concurrently with the filing of the declaration provided for in section 41-2908[, Idaho Code], the attorney of a domestic reciprocal insurer shall file with the director a bond in favor of the state of Idaho for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his bond as set forth in subsection (2) hereof. The bond shall be executed by the attorney and by an authorized corporate surety, and shall be subject to the director's approval.

(2) The bond shall be in the penal sum of twenty-five thousand dollars (\$25,000), aggregate in form, conditioned that the attorney will faithfully account for all monies and other property of the insurer coming into his hands, and that he will not withdraw or appropriate to his own use from the funds of the insurer, any moneys or property to which he is not entitled under the power of attorney.

(3) The bond shall provide that it is not subject to cancellation unless thirty (30) days' advance notice in writing of cancellation is given both the attorney and the director.

History.

1961, ch. 330, § 639, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the beginning of subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-2913. Deposit in lieu of bond. — In lieu of the bond required under section 41-2912[, Idaho Code], the attorney may maintain on deposit through the office of the director, a like amount in cash or in value of securities eligible for deposit under section 41-803[, Idaho Code] of this code and subject to the same conditions as the bond.

History.

1961, ch. 330, § 640, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions near the beginning and near the end of the section were added by the compiler to conform to the statutory citation style.

§ 41-2914. Action on bond. — Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any time by one or more subscribers suffering loss through a violation of its conditions, or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of the penalty of such bond.

History.

1961, ch. 330, § 641, p. 645.

§ 41-2915. Service of process — Judgment. — (1) Legal process shall be served upon a domestic reciprocal insurer by serving the insurer's attorney at his principal offices or by serving the director as the insurer's process agent under sections 41-333 and 41-334[, Idaho Code].

(2) Any judgment based upon legal process so served shall be binding upon each of the insurer's subscribers as their respective interests may appear, but in an amount not exceeding their respective contingent liabilities, if any, the same as though personal service of process was had upon each such subscriber. When all participants in a reciprocal insurer are political subdivisions of the state of Idaho, no contingent liability shall attach to individual subscribers by virtue of such participation.

History.

1961, ch. 330, § 642, p. 645; am. 1996, ch. 245, § 6, p. 775.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion at the end of subsection (1) was added by the compiler to conform to the statutory citation style.

CASE NOTES

Cited *Lumbermen's Underwriting Alliance v. Mobil Oil Corp.*, 612 F. Supp. 1166 (D. Idaho 1985).

§ 41-2916. Contributions to insurer. — The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms such funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer, and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No such withdrawal or repayment shall be made without the advance approval of the director. This section does not apply to bank loans, or to other loans made upon security.

History.

1961, ch. 330, § 643, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2917. Annual statement. — (1) The annual statement of a reciprocal insurer shall be made and filed by its attorney or the administrator of a joint powers entity.

(2) The statement shall be supplemented by such information as may be required by the director relative to the affairs and transactions of the attorney or joint powers entity insofar as they relate to the reciprocal insurer.

History.

1961, ch. 330, § 644, p. 645; am. 1996, ch. 245, § 7, p. 775.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2918. Financial condition — Method of determining. — In determining the financial condition of a reciprocal insurer the director shall apply the following rules:

(1) He shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis.

(2) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposits delinquent for ninety (90) days shall first be charged against such surplus deposit.

(3) The surplus deposits of subscribers shall not be charged as a liability.

(4) All premium deposits delinquent less than ninety (90) days shall be allowed as assets.

(5) An assessment levied upon subscribers, and not collected, shall not be allowed as an asset.

(6) The contingent liability of subscribers shall not be allowed as an asset.

(7) The computation of reserves shall be based upon premium deposits other than membership fees and without any deduction for expenses and the compensation of the attorney.

History.

1961, ch. 330, § 645, p. 645; am. 1979, ch. 318, § 3, p. 853; am. 1995, ch. 96, § 7, p. 273; am. 2005, ch. 72, § 1, p. 248.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2919. Who may be subscribers. — (1) Individuals, partnerships, associations and corporations, public or private, of this state, hereby designated as subscribers, are authorized to exchange reciprocal or interinsurance contracts with each other, or with individuals, partnerships, associations and corporations, public or private, of other states and countries, providing indemnity among themselves for any loss which may be insured against by the reciprocal insurer to which they are subscribers; except, that public corporations of this state may so insure only in an insurer which has a surplus of three hundred thousand dollars (\$300,000) or more and under an insurance contract as to which such an insured has no contingent liability.

(2) Any corporation now or hereafter organized under the laws of this state shall, in addition to the rights, powers and franchises specified in its articles of incorporation have full power and authority to exchange insurance contracts of the kind and character mentioned in subsection (1) above. The right to exchange such contracts is declared to be incidental to the purposes for which such corporations are organized and as much granted as the rights and powers expressly conferred.

(3) Governmental entities of this state as defined by [section 6-902, Idaho Code](#), may insure with a domestic reciprocal insurer authorized to do business in this state as a reciprocal insurer so long as said governmental entity insurer has complied with the applicable provisions of this title.

(4) Any officer, representative, trustee, receiver, or legal representative of any such subscriber shall be recognized as acting for or on its behalf for the purpose of such contract but shall not be personally liable upon the contract by reason of acting in such representative capacity.

History.

1961, ch. 330, § 646, p. 645; am. 1979, ch. 318, § 4, p. 853.

§ 41-2920. Subscribers' advisory committee. — (1) The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

(2) Not less than two-thirds (2/3) of such committee shall be subscribers other than the attorney, or any person employed by, representing, or having a financial interest in the attorney.

(3) The committee shall: (a) Supervise the finances of the insurer; (b) Supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney; (c) Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and (d) Have such additional powers and functions as may be conferred by the subscribers' agreement.

History.

1961, ch. 330, § 647, p. 645.

§ 41-2921. Subscribers' liability. — (1) The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer shall be an individual, several and proportionate liability, and not joint. When all participants in a reciprocal insurer are political subdivisions of the state of Idaho, no liability shall attach to individual subscribers which is not consistent with constitutional or statutory limitations thereon.

(2) Except as to a nonassessable policy, each subscriber shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while his policy was in force. Such contingent liability may be at the rate of not less than one (1) nor more than ten (10) times the premium or premium deposit stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in section 41-2925[, Idaho Code] of this chapter.

(3) Each assessable policy issued by the insurer shall contain a statement of the contingent liability, set in type of the same prominence as the insuring clause.

History.

1961, ch. 330, § 648, p. 645; am. 1996, ch. 245, § 8, p. 775.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of subsection (2) was added by the compiler to conform to the statutory citation style.

CASE NOTES

Cited *Lumbermen's Underwriting Alliance v. Mobil Oil Corp.*, 612 F. Supp. 1166 (D. Idaho 1985).

§ 41-2922. Subscribers' liability on judgment. — (1) No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for thirty (30) days.

(2) Any such judgment shall be binding upon each subscriber only in such proportion as his interests may appear and in amount not exceeding his contingent liability, if any.

History.

1961, ch. 330, § 649, p. 645.

CASE NOTES

Cited *Lumbermen's Underwriting Alliance v. Mobil Oil Corp.*, 612 F. Supp. 1166 (D. Idaho 1985).

§ 41-2923. Assessments. — (1) Assessments may from time to time be levied upon subscribers of a domestic reciprocal insurer liable therefor under the terms of their policies by the attorney upon approval in advance by the subscribers' advisory committee and the director; or by the director in liquidation of the insurer.

(2) Each subscriber's share of a deficiency for which an assessment is made, but not exceeding in any event his aggregate contingent liability as computed in accordance with section 41-2925[, Idaho Code] of this chapter, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment.

(3) In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.

(4) No subscriber shall have an offset against any assessment for which he is liable, on account of any claim for unearned premium or losses payable.

History.

1961, ch. 330, § 650, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the middle of subsection (2) was added by the compiler to conform to the statutory citation style.

§ 41-2924. Time limit for assessment. — Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for, and shall pay his share of any assessment, as computed and limited in accordance with this chapter, if:

(1) While his policy is in force or within one year after its termination, he is notified by either the attorney or the director of his intentions to levy such assessment, or (2) If an order to show cause why a receiver, conservator, rehabilitator or liquidator of the insurer should not be appointed is issued while his policy is in force or within one year after its termination.

History.

1961, ch. 330, § 651, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-2925. Aggregate liability. — No one policy or subscriber as to such policy, shall be assessed or charged with an aggregate of contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year, in excess of the amount provided for in the power of attorney or in the subscribers' agreement, computed solely upon premium earned on such policy during that year.

History.

1961, ch. 330, § 652, p. 645.

§ 41-2926. Nonassessable policies. — (1) Nongovernmental entities. If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the total surplus required in [section 41-313, Idaho Code](#), as to such insurer, upon application of the attorney and as approved by the subscribers' advisory committee the director shall issue his certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this state, and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this state for so long as all such surplus remains unimpaired.

(2) Upon impairment of such surplus, the director shall forthwith revoke the certificate. Such revocation shall not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has theretofore been paid; but after such revocation no policy shall be issued or renewed without providing for contingent assessment liability of the subscriber.

(3) The director shall not authorize a domestic reciprocal insurer so to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualifies to and does extinguish such liability of all its subscribers and in all such policies for all kinds of insurance transacted by it. Except, that if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in such state, and need not extinguish the contingent liability applicable to policies theretofore in force in such state.

History.

1961, ch. 330, § 653, p. 645; am. 1979, ch. 318, § 5, p. 853; am. 1995, ch. 96, § 8, p. 273; am. 2005, ch. 72, § 2, p. 248.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 9 of S.L. 1995, ch. 96 declared an emergency. Approved March 13, 1995.

§ 41-2927. Distribution of savings. — A reciprocal insurer may from time to time return to its subscribers any unused premiums, savings or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks, or policies, or between subscribers, but this shall not prevent retrospective rating, nor distribution on a retrospective plan.

History.

1961, ch. 330, § 654, p. 645.

§ 41-2928. Subscribers' share in assets. — Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus made as provided in section 41-2916[, Idaho Code] of this chapter, and the return of any unused premium, savings, or credits then standing on subscribers' accounts, shall be distributed to its subscribers who were such within the twelve (12) months prior to the last termination of its certificate of authority, according to such reasonable formula as the director may approve.

History.

1961, ch. 330, § 655, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the middle of the section was added by the compiler to conform to the statutory citation style.

§ 41-2929. Merger or conversion. — (1) A domestic reciprocal insurer upon affirmative vote of not less than two-thirds (2/3) of its subscribers who vote on such merger pursuant to due notice and the approval of the director of the terms therefor, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

(2) Such a stock or mutual insurer shall be subject to the same capital or surplus requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

(3) The director shall not approve any plan for such merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to his interest in the reciprocal insurer as determined in accordance with section 41-2928[, Idaho Code,] and a reasonable length of time within which to exercise such right.

History.

1961, ch. 330, § 656, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of subsection (3) was added by the compiler to conform to the statutory citation style.

§ 41-2930. Impaired reciprocals. — (1) If the assets of a reciprocal insurer are at any time insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others, and to maintain the required surplus, its attorney shall forthwith make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency; but subject to the limitation set forth in the power of attorney or policy.

(2) If the attorney fails to make up such deficiency or to make the assessment within thirty (30) days after the director orders him to do so, or if the deficiency is not fully made up within sixty (60) days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this code.

(3) If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to limits as provided by this chapter, as the director determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons, but including the reasonable cost of the liquidation.

History.

1961, ch. 330, § 657, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Chapter 30
IDAHO UNCLAIMED LIFE INSURANCE BENEFITS ACT

Sec.

41-3001. Definitions.

41-3002. Insurer conduct.

41-3003. Unfair trade practices.

§ 41-3001. Definitions. — As used in this chapter:

(1) “Contract” means an annuity contract. The term “contract” shall not include an annuity used to fund an employment-based retirement plan or program where: (a) The insurer does not perform the recordkeeping services; or (b) The insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(2) “Death master file” means the United States social security administration’s death master file or any other database or service that is at least as comprehensive as the United States social security administration’s death master file for determining that a person has reportedly died.

(3) “Death master file match” means a search of the death master file that results in a match of the social security number or the name and date of birth of an insured, annuity owner or retained asset account holder.

(4) “Knowledge of death” means:

- (a) Receipt of an original or valid copy of a certified death certificate; or
- (b) A death master file match validated by the insurer in accordance with [section 41-3002, Idaho Code](#).

(5) “Policy” means any policy or certificate of life insurance that provides a death benefit. The term “policy” shall not include: (a) Any policy or certificate of life insurance that provides a death benefit under an employee benefit plan that is: (i) Subject to the employee retirement income security act of 1974, [29 U.S.C. section 1002](#), as periodically amended; or (ii) Under any federal employee benefit program; (b) Any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement; (c) Any policy or certificate of credit life or accidental death insurance; or (d) Any policy issued to a group master policyholder for which the insurer does not provide recordkeeping services.

(6) “Recordkeeping services” means those circumstances under which the insurer has agreed with a group policy or contract customer to be responsible for obtaining, maintaining and administering in its own or its agents’ systems information about each individual insured under an

insured's group insurance contract, or a line of coverage thereunder, at least the following information: (a) Social security number or name and date of birth; (b) Beneficiary designation information;

(c) Coverage eligibility;

(d) Benefit amount; and

(e) Premium payment status.

(7) "Retained asset account" means any mechanism whereby the settlement of proceeds payable under a policy or contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

History.

I.C., § 41-3001, as added by 2015, ch. 74, § 1, p. 194.

STATUTORY NOTES

Prior Laws.

Former chapter 30, title 41, Mutual Benefit Associations, consisting of §§ 41-3001 to 41-3047, which comprised 1947, ch. 243, §§ 5 to 15, 17 to 19, 21 to 38, 40, p. 597; am. 1951, ch. 67, § 12, p. 21; am. 1951, ch. 98, §§ 1 to 5, p. 222; am. 1953, ch. 114, §§ 1 to 5, p. 160; 1957, ch. 159, § 1, p. 282; 1961, ch. 330, § 658, p. 645; am. 1979, ch. 122, § 3, p. 375; am. 1984, ch. 23, § 9, p. 38, were repealed by S.L. 1987, ch. 78, § 1.

Compiler's Notes.

The social security administration death master file, referred to in subsection (2), is a database file made available by the social security administration since 1980. It is known commercially as the social security death index. See <https://www.ssdmf.com/>.

Effective Dates.

Section 2 of S.L. 2015, chapter 74 made the act effective July 1, 2016.

§ 41-3002. Insurer conduct. — (1) An insurer shall perform a comparison of its insureds' in-force policies, contracts and retained asset accounts against a death master file, on at least a semiannual basis, by using the full death master file once and thereafter using the death master file update files for future comparisons to identify potential matches of its insureds. For those potential matches identified as a result of death master file match, the insurer shall:

(a) Within ninety (90) days of a death master file match: (i) Complete a good faith effort, which shall be documented by the insurer, to confirm the death of the insured, annuity owner or retained asset account holder against other available records and information; (ii) Determine whether benefits are due in accordance with the applicable policy or contract; and (iii) If benefits are due in accordance with the applicable policy or contract, use good faith efforts, which shall be documented by the insurer, to locate the beneficiary or beneficiaries and provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim including the need to provide an official death certificate, if applicable under the policy or contract.

(b) With respect to group life insurance, insurers are required to confirm the possible death of an insured when the insurers maintain at least the following information of those covered under a policy or certificate: (i) Social security number or name and date of birth; (ii) Beneficiary designation information;

(iii) Coverage eligibility;

(iv) Benefit amount; and

(v) Premium payment status.

(c) Every insurer shall implement procedures to account for: (i) Common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names and interchanged first and middle names; (ii) Compound last names, maiden or married names and hyphens, and blank spaces or apostrophes in last names; (iii)

Transposition of the month and date portions of the date of birth; and (iv) Incomplete social security number.

(d) To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer locate the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(2) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(3) The benefits from a policy, contract or a retained asset account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners and in the event such beneficiaries or owners cannot be found shall escheat to the state as unclaimed property pursuant to [section 14-507, Idaho Code](#). Interest payable under [section 41-1337, Idaho Code](#), shall not be payable as unclaimed property under [section 14-507, Idaho Code](#).

(4) An insurer shall notify the unclaimed property administrator upon the expiration of the statutory time period for escheat that: (a) A policy or contract beneficiary or retained asset account holder has not submitted a claim with the insurer; and (b) The insurer has complied with subsection (1) (a) of this section and has been unable, after good faith efforts documented by the insurer, to contact the retained asset account holder, beneficiary or beneficiaries.

(5) Upon such notice, an insurer shall immediately submit the unclaimed policy or contract benefits or unclaimed retained asset accounts, plus any applicable accrued interest, to the unclaimed property administrator.

History.

[I.C., § 41-3002](#), as added by 2015, ch. 74, § 1, p. 194.

STATUTORY NOTES

Cross References.

State treasurer as administrator of unclaimed property, § 14-501.

Prior Laws.

Former § 41-3002 was repealed. See Prior Laws, § 41-3001.

Effective Dates.

Section 2 of S.L. 2015, chapter 74 made the act effective July 1, 2016.

§ 41-3003. Unfair trade practices. — Failure to meet any requirement of this act with such frequency as to constitute a general business practice is a violation of chapter 13, title 41, Idaho Code. Nothing contained in this section shall be construed to create or imply a private cause of action for a violation of this section.

History.

I.C., § 41-3003, as added by 2015, ch. 74, § 1, p. 194.

STATUTORY NOTES

Prior Laws.

Former § 41-3003 was repealed. See Prior Laws, § 41-3001.

Compiler's Notes.

The term “this act” in this section refers to S.L. 2015, Chapter 74, which is codified as §§ 41-3001 to 41-3003.

Effective Dates.

Section 2 of S.L. 2015, chapter 74 made the act effective July 1, 2016.

Chapter 31

COUNTY MUTUAL INSURERS

Sec.

41-3101. Scope of chapter — Provisions exclusive.

41-3102. Organization of county mutual fire insurers.

41-3102A. Conversion into domestic mutual.

41-3103. Filing of articles — Commencement of business.

41-3104. Insuring powers.

41-3104A. Property used to fight fires — Charges.

41-3105. Insurer's territory.

41-3106. Limit of risk.

41-3107. Reinsurance.

41-3108. Certificate of authority required.

41-3109. Directors.

41-3110. Members.

41-3111. Advance payments by members.

41-3112. Assessments.

41-3112A. Advance premiums — Return premiums.

41-3113. Expenses.

41-3114. Investments.

41-3115. Site for head office.

41-3116. Records — Annual statement.

41-3117. Amendment of articles of incorporation.

41-3118. Fees.

41-3119. Other provisions applicable.

§ 41-3101. Scope of chapter — Provisions exclusive. — (1) This chapter applies only to domestic county mutual fire insurers as heretofore organized or doing business under the provisions of title 41, **chapter 23, Idaho Code** [prior to 1961 insurance code revision], or as hereafter organized under this chapter.

(2) This chapter shall also apply as to domestic fire insurance associations or organizations heretofore formed and affiliated with and insuring only property owned by a bona fide fraternal society operating on the lodge system, or owned by members of such society. Except as otherwise expressly provided for, such associations or organizations, hereinafter referred to as “fraternal insurers,” are also included within the terms “insurer” or “county mutual fire insurer” as used in this chapter.

(3) No provision of this code shall apply to such insurers unless contained or referred to in this chapter.

History.

1961, ch. 330, § 659, p. 645.

STATUTORY NOTES

Compiler’s Notes.

The bracketed words “prior to 1961 insurance code revision” were inserted by the compiler because a former chapter 23 of title 41, referred to in subsection (1) of this section, was repealed by S.L. 1961, ch. 330, § 809.

§ 41-3102. Organization of county mutual fire insurers. — (1) Twenty-five (25) or more citizens of Idaho, each of whom shall be owner of substantial insurable property in a county of this state within which the insurer proposes to do business, may hereafter incorporate a county mutual fire insurer.

(2) The incorporators shall prepare and execute in quadruplicate articles of incorporation setting forth:

- (a) The name of the corporation, which shall contain the words “county mutual fire insurance company” preceded by a distinctive name which is not so similar to that of any other authorized insurer as to be likely to confuse or mislead;
- (b) The county or counties of this state within which the insurer proposes to do business, and the name of the town or city therein in which the insurer’s head office is to be located;
- (c) The objects for which the corporation is formed, including the property to be insured and the perils to be assumed by the insurer, which shall not be in excess of the insuring power of such an insurer as set forth in this chapter;
- (d) That insurance shall be limited to members of the insurer, and that each such member shall be liable to assessment for payment of the losses and expenses of the insurer, and that such liability may be enforced by the corporation;
- (e) The duration of the corporation’s existence, which may be for a specified term of years or perpetual;
- (f) The name, residence address in this state, and citizenship of each incorporator;
- (g) The names of the corporation’s initial board of directors, not less than nine (9) in number, who shall manage the insurer’s affairs for a specified term which shall not exceed one (1) year from date of incorporation; and
- (h) Such other lawful provisions as may be necessary or desirable.

(3) The articles of incorporation so executed shall be acknowledged by at least three (3) of the incorporators before an officer authorized to take acknowledgment of deeds.

History.

1961, ch. 330, § 660, p. 645.

STATUTORY NOTES

Cross References.

Acknowledgments, § 55-701 et seq.

§ 41-3102A. Conversion into domestic mutual. — (1) A county mutual insurer upon affirmative vote of not less than two-thirds (2/3) of its members who vote on such conversion, pursuant to due notice, and the approval of the director of the terms therefor, may be converted to a domestic mutual insurer.

(2) A domestic mutual insurer which has converted from a county mutual insurer shall be subject to the same requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance, except that prior to June 30, 2004, surplus as regards policyholders may be maintained at a level equal to fifty percent (50%) net written premium in the calendar year preceding, with a minimum set at one million dollars (\$1,000,000).

(3) The director shall not approve any plan for such conversion which is inequitable to members.

History.

I.C., § 41-3102A, as added by 1979, ch. 40, § 1, p. 62; am. 1994, ch. 240, § 7, p. 751; am. 2000, ch. 299, § 1, p. 1030.

STATUTORY NOTES

Compiler's Notes.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable

limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

§ 41-3103. Filing of articles — Commencement of business. — (1)

The articles of incorporation of a proposed new county mutual fire insurer, after due execution and acknowledgment as provided in section 41-3102[, Idaho Code], shall be filed as required by those provisions of section 41-2805[, Idaho Code] (filing of articles) applying to mutual insurers.

(2) After the articles of incorporation have been so filed, the directors shall adopt by-laws, elect officers, and apply to the director for a certificate of authority as a county mutual fire insurer. Upon issuance of the certificate of authority the insurer may commence business as a county mutual fire insurer.

History.

1961, ch. 330, § 661, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in subsection (1) were added by the compiler to conform to the statutory citation style.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-3104. Insuring powers. — Within the limits of restrictions set forth in its articles of incorporation and otherwise under this chapter, such an insurer may:

(1) Issue property insurance, as defined in [section 41-504, Idaho Code](#), as to farm property and personal property reasonably associated therewith, churches and public halls, and certain other dwellings and property as specified below, all as follows:

(a) The property insured must be owned by a member of the insurer, and must (except as expressly provided in this section) be located within the county or counties in which the insurer is authorized to transact insurance as provided in [section 41-3105, Idaho Code](#);

(b) The insurer shall not insure any property located within the limits of any incorporated city, town, or village, except as follows:

(i) The insurer may insure dwellings and/or household goods owned by its members who, after becoming such members, have moved within the limits of any such incorporated city, town, or village;

(ii) The insurer may insure property of a member located upon an otherwise open tract of land occupied by the member and not less than five (5) acres in area, within the limits of any such city, town, or village; and

(iii) The insurer may insure grange halls, wherever located in this state.

(2) The insurer may insure other buildings and/or contents owned by its members individually or as an organization and not located within any city, town, or village with population in excess of one hundred twenty-five (125).

(3) The insurer may insure churches and other public halls only if located outside of incorporated cities, towns, and villages.

(4) The insurer may insure farm machinery wherever located against fire, theft, and upset, or against fire and such additional perils as are usually insured under an extended coverage indorsement.

History.

1961, ch. 330, § 662, p. 645; am. 1963, ch. 48, § 1, p. 199; am. 1969, ch. 211, p. 612; am. 1977, ch. 142, § 10, p. 303.

STATUTORY NOTES

Compiler's Notes.

The words in parentheses so appeared in the law as enacted.

CASE NOTES

Decisions Under Prior Law

[Nonmembers ineligible for insurance.](#)

[Policies.](#)

[Nonmembers Ineligible for Insurance.](#)

An agent of a county mutual fire company could not enter into a valid contract to insure the property of a nonmember and such company could not be held liable in an action upon a contract based upon an agreement for or of insurance with a nonmember. [Telford v. Bingham County Farmers' Mut. Ins. Co., 52 Idaho 461, 16 P.2d 983 \(1932\).](#)

[Policies.](#)

Policies of a county mutual fire insurance company must be in writing; they could only be issued to members of the company; before anyone could become a member, he must sign the constitution and by-laws and, thus, agree in writing to be bound by them. [Telford v. Bingham County Farmers' Mut. Ins. Co., 52 Idaho 461, 16 P.2d 983 \(1932\).](#)

The secretary of the company must approve the application and must countersign the policy in order to render it valid. [Telford v. Bingham County Farmers' Mut. Ins. Co., 52 Idaho 461, 16 P.2d 983 \(1932\).](#)

§ 41-3104A. Property used to fight fires — Charges. — Any county mutual fire insurer may acquire and dispose of real and personal property necessary to prevent, abate or extinguish fires.

Non-discriminatory, reasonable charges based on insurable value, as approved by the director, may be assessed against any owner who has received services from a county mutual fire insurer to prevent, abate or extinguish fires.

Activities authorized under this section shall not necessarily be limited to members or to the insurer's territory.

History.

I.C., § 41-3104A, as added by 1972, ch. 143, § 1, p. 310.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 2 of S.L. 1972, ch. 143 declared an emergency. Approved March 17, 1972.

§ 41-3105. Insurer's territory. — An insurer shall insure only such property as it is otherwise authorized to insure under this chapter, and which is located within one (1) or more of the counties of this state within which the insurer may transact insurance as provided by its articles of incorporation, subject to the following conditions:

(1) An insurer which has less than seven million dollars (\$7,000,000) of insurance in force on separate properties shall not transact insurance in an area greater than that of the county in which its head office is located, together with not more than the four (4) Idaho counties contiguous with such head office county; (2) An insurer which has seven million dollars (\$7,000,000) but less than twelve million dollars (\$12,000,000) of insurance in force on separate properties may transact insurance in the county in which its head office is located together with not more than the eight (8) Idaho counties most adjacent to such head office county; (3) An insurer which has twelve million dollars (\$12,000,000) or more of insurance in force on separate properties may transact insurance in the county in which its head office is located together with not more than the twelve (12) Idaho counties most adjacent to such head office county and/or may extend its activities and operations into an adjoining state; and (4) A fraternal insurer may operate under this chapter in any or all of the counties of this state.

History.

1961, ch. 330, § 663, p. 645.

§ 41-3106. Limit of risk. — (1) The maximum amount of insurance which an insurer shall retain as to any one (1) subject of insurance, after deduction of applicable reinsurance, shall not exceed ten per cent (10%) of the insurer's admitted assets or twenty-five thousand dollars (\$25,000), whichever is the larger amount.

(2) As to insurance against fire and perils other than windstorm, tornado, hailstorm, and other catastrophic perils, a "subject of insurance" for the purposes of this provision includes all properties insured by the same insurer which are customarily considered by insurance underwriters to be subject to loss or damage from the same fire or the same occurrence of any other peril insured against.

History.

1961, ch. 330, § 664, p. 645; am. 1978, ch. 109, § 1, p. 227.

§ 41-3107. Reinsurance. — A county mutual fire insurer may cede reinsurance to another county mutual fire insurer or to any insurer authorized in this state to transact the kind of insurance involved or approved by the director. A county mutual fire insurer shall accept reinsurance only from another county mutual fire insurer.

History.

1961, ch. 330, § 665, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3108. Certificate of authority required. — (1) No county mutual fire insurer shall transact insurance except as authorized by a subsisting certificate of authority issued to it by the director.

(2) To apply for a certificate of authority the insurer shall file with the director its written application therefor showing: (a) The name and head office address of the insurer;

(b) The name, residence address, and occupation of each of the insurer's directors and officers; (c) The kinds of insurance proposed to be transacted; (d) The Idaho counties in which the insurer proposes to transact insurance; and (e) Such other and additional information relative to the insurer as the director may reasonably require.

(3) The application shall be accompanied by such of the following as may not already be on file with the director: (a) Copy of the insurer's articles of incorporation and of its by-laws, each certified by the insurer's corporate secretary; (b) Copy of the insurer's financial statement as of a date within three (3) months prior to the filing of the application; (c) Copy of form of insurance policy or policies proposed to be issued; (d) Schedule of or statement as to sums proposed to be collected in advance at time of issuance of insurance; and (e) Fee for issuance of the certificate of authority in the amount specified in section 41-3118[, Idaho Code] (fee schedule).

(4) If the director finds the application and accompanying documents to be consistent with law, he shall issue the insurer a certificate of authority; otherwise, the director shall deny the application for certificate of authority by written order stating the grounds for such denial and refund to the applicant any sum tendered as fee for issuance of the certificate.

(5) Certificates of authority issued under this section shall continue in force as long as the insurer is entitled thereto under this code and until suspended or revoked by the director, or terminated at the request of the insurer; subject, however, to continuance of the certificate by the insurer each year by payment prior to March 1 of the continuation fee provided in section 41-3118[, Idaho Code] (fee schedule) and due filing by the insurer of its annual statement for the calendar year preceding as required under

section 41-3116[, Idaho Code]. If not so continued by the insurer, its certificate of authority shall expire as at [of] midnight on the March 31 next following such failure of the insurer to continue it in force.

History.

1961, ch. 330, § 666, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in paragraph (3)(e) and near the end of the first sentence in subsection (5) were added by the compiler to conform to the statutory citation style.

The bracketed word “of” in the last sentence in subsection (5) was inserted by the compiler to supply the seemingly intended word.

The words in parentheses so appeared in the law as enacted.

§ 41-3109. Directors. — (1) The affairs of the insurer shall be under the direction of a board of directors comprised of not less than nine (9) nor more than twenty-five (25) members of the insurer.

(2) After expiration of the term of initial directors, if any, as provided for in the articles of incorporation, directors shall be elected at the annual meeting of the insurer's members for terms of not more than three (3) years each. If terms of more than one (1) year are used, the terms of directors shall be staggered so that the terms of a proportionate number of directors will expire each year.

(3) A director may also act as an agent for the insurer with the same but not greater contract authority as any other agent.

History.

1961, ch. 330, § 667, p. 645; am. 1983, ch. 46, § 1, p. 116.

§ 41-3110. Members. — (1) Every policyholder of the insurer is thereby a member of the insurer, with all of the rights and liabilities of membership.

(2) All policies issued by the insurer shall state specifically that the liability of each member is not limited. All persons becoming members of the insurer shall sign the constitution and by-laws, and shall be held in law to comply with all the provisions and requirements of the insurer.

(3) Each member shall have one (1) vote and no more in the election of a director and on any other matter coming to a vote at meetings of members. A member may vote in person or by proxy, or by mail, but no person shall vote more than five (5) proxies.

History.

1961, ch. 330, § 668, p. 645.

CASE NOTES

Decisions Under Prior Law

Agreement for increased coverage.

Limit of liability.

Negligent failure to issue policy.

Agreement for Increased Coverage.

The secretary of the company was acting within both the real and apparent scope of his authority when he told a member that it was unnecessary for such member to file a new application for insurance on his dwelling but that he, the secretary, would amend the original application so as to include such dwelling and the company was bound by his action. *Telford v. Bingham County Farmers' Mut. Ins. Co.*, 52 Idaho 461, 16 P.2d 983 (1932).

Limit of Liability.

Person can not become member without becoming an insurer of property of other members and his liability would be limited only by amount of

insurance in force and solvency of members. *School Dist. No. 8 v. Twin Falls County Mut. Fire Ins. Co.*, 30 Idaho 400, 164 P. 1174 (1917).

Negligent Failure to Issue Policy.

A company was liable for the negligence of its secretary in failing to issue a policy covering a member's dwelling when the member inquired about the fees and charges due for the inclusion of his dwelling and was told by the secretary that he could "fix it" later on and no demand for payment was made. *Telford v. Bingham County Farmers' Mut. Ins. Co.*, 52 Idaho 461, 16 P.2d 983 (1932).

§ 41-3111. Advance payments by members. — The insurer shall not charge the member, and no member of the insurer shall pay to the insurer, in connection with the inception of insurance in the insurer or any renewal or continuation of such insurance, any charge or amount in excess of such amount as may be reasonably necessary for payment of the member's share of the insurer's expenses (exclusive of insured losses incurred) to be incurred during the next succeeding twelve (12) months, and for maintenance or replenishment of the emergency fund provided for in section 41-3112(3)[, Idaho Code]. This provision shall not be deemed to prohibit the levy and collection of assessments for payment of incurred losses or for maintenance of the emergency fund, as provided for in section 41-3112[, Idaho Code], nor collection of membership or policy fees in fixed nominal amounts.

History.

1961, ch. 330, § 669, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions near the ends of the first and second sentences were added by the compiler to conform to the statutory citation style.

The words in parentheses so appeared in the law as enacted.

§ 41-3112. Assessments. — (1) A county mutual fire insurer may from time to time assess and collect from its members, and from the owners or trustees of churches or public halls insured by it, such sums of money as may be necessary to pay losses incurred under policies issued by the insurer, from time to time as such losses occur, and to pay such fire protection expenses and other expenses of the insurer as may have been approved by the board of directors consistent with section 41-3113[, Idaho Code].

(2) The insurer may classify its policies for assessment purposes in accordance with types and circumstances of properties and hazards insured, and may vary the amount of assessment as applied to the respective such classes, if the insurer maintains adequate records from which the loss experience of the respective classes can readily be determined.

(3) The levy and collection of assessments shall be regulated by the insurer's constitution and by-laws. But no assessment to cover insured losses incurred shall be levied in advance of the occurrence of the losses on account of which the assessment is made; except, that the insurer may, in its by-laws, provide for an emergency fund, which fund shall at no time exceed ten thousand dollars (\$10,000) or one percent (1%) of the amount of insurance in force, whichever is the larger sum, out of which fund losses to the extent of the money therein may be immediately paid.

History.

1961, ch. 330, § 670, p. 645.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion at the end of subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-3112A. Advance premiums — Return premiums. — (1) Advance premiums. A county mutual insurer having a surplus over all liabilities of not less than \$50,000, including a liability for unearned premiums, and for so long as such surplus is continuously maintained, such insurer may bill and collect assessments on the advance premium basis.

(2) Return premium. Upon the termination of any policy of insurance during any effective policy year, the unearned premium shall be returned to a member policyholder in accordance with the rules for pro-rata and short rate cancelations applying to casualty insurance policies.

(3) The limitations as to the emergency fund imposed by section 41-3112(3)[, Idaho Code,] shall not apply to a county mutual insurer qualifying under this section to collect premiums in advance.

History.

I.C., § 41-3112A, as added by 1965, ch. 277, § 1, p. 724.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in subsection (3) was added by the compiler to conform to the statutory citation style.

Section 2 of S.L. 1965, ch. 277, read: “Separability. — If any part or provision of this act shall be found to be invalid or ineffective by any court, such finding shall not effect the legality of the balance of this act, nor any part thereof.”

§ 41-3113. Expenses. — (1) The operating expenses of the insurer shall be reasonable in amount in relation to the volume of business transacted and insurance losses incurred.

(2) The insurer's by-laws shall contain reasonable limitations of all such expenses, and such provisions and all modifications thereof shall be subject to the director's approval.

History.

1961, ch. 330, § 671, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner's" has been changed to "director's" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3114. Investments. — (1) The insurer may invest and have invested such funds as it may have on hand pursuant to this chapter but not necessary to expend for current expenses and losses, in investments as authorized by the following sections of the Idaho Code only:

(a) Section 41-707[, Idaho Code] (public obligations);

(b) Section 41-708[, Idaho Code] (obligations, stock of certain federal agencies); (c) Section 41-709[, Idaho Code] (irrigation district bonds); (d) Section 41-716[, Idaho Code] (investment trust securities); (e) Section 41-720[, Idaho Code] (savings and share accounts); (f) Sections 41-721 through 41-725[, Idaho Code] (mortgage loans), as to mortgage loans on Grange halls only; and (g) Section 41-3115[, Idaho Code] (site for head office).

(2) The following sections of the Idaho Code shall to the extent applicable, also apply with respect to such an insurer: (a) Section 41-702[, Idaho Code] (eligible investments); (b) Section 41-703[, Idaho Code] (general qualifications); (c) Section 41-704[, Idaho Code] (authorization of investments); (d) Section 41-705[, Idaho Code] (record of investments); (e) Section 41-706(1)[, Idaho Code] (diversification of investments in securities, *etc.* of any one person); (f) Section 41-730[, Idaho Code] (disposal of ineligible property and securities); and (g) Section 41-731[, Idaho Code] (prohibited investments and investment underwriting).

History.

1961, ch. 330, § 672, p. 645; am. 1984, ch. 241, § 1, p. 587.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions throughout the section were added by the compiler to conform to the statutory citation style.

The words in parentheses so appeared in the law as enacted.

§ 41-3115. Site for head office. — (1) The board of directors of an insurer may purchase, hold and convey in the name of and for the insurer, real estate for a site for its principal or head office when authorized so to do by the affirmative vote of a majority of the members present in person or by proxy in adoption of a resolution for that purpose at any annual meeting of the insurer's members or any special meeting of the members called for the purpose. The resolution shall name the city or town or village within the insurer's territory in which the site shall be purchased. When the site is so purchased the insurer may transact any or all of its business, including the annual or any special meeting of its members, in such city, town or village.

(2) The resolution for purchase of the site shall also limit the amount of the insurer's funds that can be invested therein, and in the improvements thereon or to be constructed thereon. Any such resolution hereafter adopted shall be subject to the director's approval. The director shall approve the resolution unless he finds, after a hearing thereon, that the procedure leading to adoption of the resolution was unlawful or that the amounts to be so expended are excessive.

(3) The insurer shall dispose of such head office property within five (5) years after it ceases to be used or to be necessary for head office purposes, subject to the right of the director to grant a reasonable extension of time upon proof satisfactory to him that the insurer will suffer materially by an earlier forced sale of the property.

History.

1961, ch. 330, § 673, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3116. Records — Annual statement. — (1) The insurer shall keep at its head office records and accounts of its transactions, claims, and affairs in such form and with such completeness as may be reasonably necessary for the identification and examination thereof.

(2) Annually on or before March 1 the insurer shall file with the director a full and true statement of its financial condition, transactions and affairs as of the December 31 preceding. The statement shall be in such general form as is required or accepted by the director.

History.

1961, ch. 330, § 674, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3117. Amendment of articles of incorporation. — (1) The articles of incorporation of such an insurer may be amended in any lawful respect by approval by its board of directors by affirmative vote of at least two-thirds (2/3) of all its directors and by adoption thereafter by affirmative vote of not less than two-thirds (2/3) of the insurer's members present or represented by proxy at any meeting of members, at which a quorum as required by the insurer's constitution or by-laws was present, and if the notice of such meeting contained notice of the proposed amendment.

(2) An amendment so adopted shall be filed in accordance with the applicable provisions of section 41-2827(2)[, Idaho Code]; except that the fee for the filing of the amendment with the director shall be as provided in [section 41-3118, Idaho Code](#). The filing fee shall not be subject to refund.

History.

1961, ch. 330, § 675, p. 645; am. 1984, ch. 23, § 4, p. 38.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion in the first sentence in subsection (2) was added by the compiler to conform to the statutory citation style.

§ 41-3118. Fees. — (1) Every county mutual fire insurer shall pay to the director all fees in advance as provided for by regulation.

(2) The director shall transmit and report all fees so collected by him as provided in [section 41-406, Idaho Code](#).

History.

[I.C., § 41-3118](#), as added by 1984, ch. 23, § 5, p. 38.

STATUTORY NOTES

Prior Laws.

Former § 41-3118, which comprised 1961, ch. 330, § 676, p. 645; am. 1979, ch. 122, § 4, p. 375, was repealed by S.L. 1984, ch. 23, § 1.

§ 41-3119. Other provisions applicable. — The following chapters and provisions of this code shall also apply to county mutual fire insurers to the extent so applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of such express provisions:

(1) Chapter 1[, title 41, Idaho Code] (scope of code);

(2) Chapter 2[, title 41, Idaho Code] (the director of the department of insurance); (3) The following provisions of chapter 3[, title 41, Idaho Code] (authorization of insurers and general requirements): (a) Section 41-305[, Idaho Code] (certificate of authority required); (b) Section 41-308(2)[, Idaho Code] (general eligibility for certificate of authority); (c) Section 41-311[, Idaho Code] (name of insurer);

(d) Section 41-323[, Idaho Code] (what certificate evidences — ownership of certificate); (e) Section 41-325[, Idaho Code] (amendment of certificate of authority); (f) Section 41-326[, Idaho Code] (suspension or revocation of certificate of authority, mandatory grounds); (g) Section 41-327[, Idaho Code] (suspension, revocation of certificate of authority, discretionary and special grounds); (h) Section 41-328[, Idaho Code] (order, notice of suspension, revocation or refusal — effect upon agents' authority); (i) Section 41-329[, Idaho Code] (duration of suspension — insurer's obligations during suspension period — reinstatement); and (j) Section 41-336[, Idaho Code] (review of annual statement — additional information); (4) Section 41-510[, Idaho Code] (“reinsurance” defined);

(5) The following sections of chapter 6[, title 41, Idaho Code] (assets and liabilities): (a) Sections 41-601[, Idaho Code] (“assets” defined), 41-602[, Idaho Code] (assets as deductions from liabilities), and 41-603[, Idaho Code] (assets not allowed); (b) Section 41-604[, Idaho Code] (disallowance of “wash” transactions); and (c) Sections 41-613[, Idaho Code] (valuation of bonds), 41-614[, Idaho Code] (valuation of other securities), and 41-615[, Idaho Code] (valuation of property); (6) Sections 41-1201[, Idaho Code] (representing or aiding unauthorized insurer prohibited), 41-1202[, Idaho Code] (representing or aiding unauthorized insurer prohibited — penalty), and 41-1203[, Idaho Code] (suits by unauthorized insurer

prohibited); (7) Chapter 13[, title 41, Idaho Code] (trade practices and frauds);

(8) Chapter 18[, title 41, Idaho Code] (the insurance contract);

(9) Section 41-2401[, Idaho Code] (standard fire policy);

(10) The following provisions of chapter 28[, title 41, Idaho Code] (organization and corporate procedures of stock and mutual insurers): (a) Section 41-2803[, Idaho Code] (applicability of general corporation statutes); (b) Section 41-2828[, Idaho Code] (insurance business exclusive);

(c) Section 41-2829[, Idaho Code] (membership in mutuals);

(d) Section 41-2830[, Idaho Code] (by-laws of mutual);

(e) Section 41-2831[, Idaho Code] (rights of mutual members, in general); (f) Section 41-2832[, Idaho Code] (meetings of members of mutual insurer); (g) Section 41-2833[, Idaho Code] (special meetings of members of mutual insurer); (h) Section 41-2836[, Idaho Code] (notice of change of directors, officers); (i) Section 41-2837[, Idaho Code] (prohibited pecuniary interest of officials) except agents may also serve as directors of county mutual insurers; (j) Section 41-2838[, Idaho Code] (management and exclusive agency contracts); (k) Section 41-2839[, Idaho Code] (home office, records, and assets; penalty for unlawful removal); (l) Section 41-2840[, Idaho Code] (vouchers for expenditures);

(m) Section 41-2841[, Idaho Code] (borrowed surplus);

(n) Section 41-2851[, Idaho Code] (solicitations in other states);

(o) Sections 41-2857[, Idaho Code] (mergers and consolidations, mutual insurers) and 41-2858[, Idaho Code] (bulk reinsurance, mutual insurers); and (p) Section 41-2859[, Idaho Code] (mutual member's share of assets on liquidation).

(11) Chapter 33[, title 41, Idaho Code] (rehabilitation and liquidation); and (12) Sections 799 to 809 of chapter 330 of the session laws of 1961 (transitory provisions).

History.

1961, ch. 330, § 677, p. 645; am. 1983, ch. 46, § 2, p. 116.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Chapter 33 (Rehabilitation and Liquidation), referred to in subsection (11), was repealed by S.L. 1981, ch. 249 and replaced by a new chapter 33, title 41, Idaho Code (Insurers Supervision, Rehabilitation and Liquidation).

Except for Section 804, codified as § 41-118, and Section 805, codified as § 41-119, Sections 799 to 809 of chapter 330 of the session laws of 1961, referred to in subsection (12), were not codified. See Compiler's Notes, § 41-3434.

The bracketed insertions throughout the section were added by the compiler to conform to the statutory citation style.

The words in parentheses so appeared in the law as enacted.

Chapter 32

FRATERNAL BENEFIT SOCIETIES

Sec.

41-3201. Fraternal benefit societies.

41-3202. Lodge system.

41-3203. Representative form of government.

41-3204. Terms used.

41-3205. Purposes and powers.

41-3206. Qualifications for membership.

41-3207. Location of office, meetings, communications to members, grievance procedures.

41-3208. No personal liability.

41-3209. Waiver.

41-3210. Organization.

41-3211. Amendments to laws.

41-3212. Institutions.

41-3213. Reinsurance.

41-3214. Consolidations and mergers.

41-3215. Conversion of fraternal benefit society into a mutual life insurance company.

41-3216. Benefits.

41-3217. Beneficiaries.

41-3218. Benefits not attachable.

41-3219. The benefit contract.

41-3220. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

41-3221. Investments.

41-3222. Funds.

41-3223. Taxation.

41-3224. Valuation.

41-3225. Reports.

41-3226. License.

41-3227. Examination of societies — No adverse publications.

41-3228. Foreign or alien society — Admission.

41-3229. Injunction — Liquidation — Receivership of domestic society.

41-3230. Suspension, revocation or refusal of license of foreign or alien society.

41-3231. Injunction.

41-3232. Licensing of agents.

41-3233. Unfair methods of competition and unfair and deceptive acts and practices.

41-3234. Service of process.

41-3235. Fees.

41-3236. Penalties.

41-3237. Exemption of certain societies.

41-3238. Review.

41-3239. Other provisions applicable.

41-3240 — 41-3245. Taxation — Exemptions — Penalties — Fraternal benefit society fees — Applicability of other provisions. [Repealed.]

§ 41-3201. Fraternal benefit societies. — Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of [section 41-3237\(1\)\(b\), Idaho Code](#), whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

History.

[I.C., § 41-3201](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Cross References.

Life and Health Insurance Guaranty Association Act, § 41-4301 et seq.

Prior Laws.

Former § 41-3201, which comprised [I.C., § 41-3201](#), as added by 1971, ch. 98, § 2, p. 212; am. 1976, ch. 72, § 1, p. 240, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Another former § 41-3201, which comprised S.L. 1961, ch. 330, § 678, p. 645, was repealed by S.L. 1971, ch. 98, § 1, p. 212.

Effective Dates.

Section 3 of S.L. 1995, ch. 213 provided that the act shall be in full force and effect on January 1, 1996.

CASE NOTES

Decisions Under Prior Law Religious, Social, and Benevolent Corporations.

Association organized under §§ 30-1101 — 30-1109 (now repealed), providing for incorporation of religious, social, and benevolent corporations, was held not to be a fraternal benefit society, and not under

jurisdiction of insurance department or subject to provisions of insurance code, although its chief purpose was to pay death benefits not exceeding three dollars (\$3.00) for each member, to be paid by assessment on other members. *State ex rel. Conner v. Western Mut. Benefit Ass'n*, 47 Idaho 360, 276 P. 37 (1929).

§ 41-3202. Lodge system. — (1) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(2) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

History.

I.C., § 41-3202, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3202, which comprised 1961, ch. 330, § 679, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3203. Representative form of government. — A society has a representative form of government when:

(1) It has a supreme governing body constituted in one (1) of the following ways:

(a) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds ($\frac{2}{3}$) of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four (4) years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(b) Direct election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four (4) years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(2) The officers of the society are elected either by the supreme governing body or by the board of directors;

(3) Only benefit members are eligible for election to the supreme governing body and the board of directors; and

(4) Each voting member shall have one (1) vote; no vote may be cast by proxy.

History.

I.C., § 41-3203, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3203, which comprised 1961, ch. 330, § 680, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3204. Terms used. — Whenever used in this chapter:

(1) “Benefit contract” shall mean the agreement for provision of benefits authorized by [section 41-3216, Idaho Code](#), as that agreement is described in [section 41-3219\(1\), Idaho Code](#).

(2) “Benefit member” shall mean an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(3) “Certificate” shall mean the document issued as written evidence of the benefit contract.

(4) “Director” shall mean the director of the department of insurance of this state.

(5) “Laws” shall mean the society’s articles of incorporation, constitution and bylaws, however designated.

(6) “Lodge” shall mean subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

(7) “Premiums” shall mean premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

(8) “Rules” shall mean all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(9) “Society” shall mean fraternal benefit society, unless otherwise indicated.

History.

[I.C., § 41-3204](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3204, which comprised 1961, ch. 330, § 681, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3205. Purposes and powers. — (1) A society shall operate for the benefit of members and their beneficiaries by:

- (a) Providing benefits as specified in [section 41-3216, Idaho Code](#); and
- (b) Operating for one (1) or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others. Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(2) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

History.

[I.C., § 41-3205](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3205, which comprised 1961, ch. 330, § 682, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3206. Qualifications for membership. — (1) A society shall specify in its laws or rules:

(a) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen (15) years and not greater than age twenty-one (21) years; (b) The process for admission to membership for each membership class; and (c) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(2) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in the society are personal to the member and are not assignable.

History.

I.C., § 41-3206, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3206, which comprised 1961, ch. 330, § 683, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3207. Location of office, meetings, communications to members, grievance procedures. — (1) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one (1) subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(2)(a) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two (2) or more members have the same mailing address, an official publication mailed to one (1) member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(b) Not later than the first day of June of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(3) A society may provide in its laws or rules for grievance or complaint procedures for members.

History.

I.C., § 41-3207, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3207, which comprised 1961, ch. 330, § 684, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3208. No personal liability. — (1) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(2) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that the person is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed: (a) in relation to any matter in such action, suit or proceeding as to which he shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society; or (b) in relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in subpoints (a) or (b) of the preceding sentence may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his heirs, executors and administrators.

(3) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society, or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him in any such capacity or arising out of his status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

(4) No director, officer, employee, member or volunteer of a society serving without compensation, shall be liable, and no cause of action may be brought, for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of such person for the society unless such act or omission involved willful or wanton misconduct.

History.

I.C., § 41-3208, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3208, which comprised 1961, ch. 330, § 685, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3209. Waiver. — The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

History.

I.C., § 41-3209, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3209, which comprised 1961, ch. 330, § 686, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3210. Organization. — A domestic society organized on or after the effective date of this act shall be formed as follows:

(1) Seven (7) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

(a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(b) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted in this chapter;

(c) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority.

(2) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one (1) year shall be filed with the director, who may require such further information as the director deems necessary. The bond with sureties approved by the director shall be in such amount, not less than three hundred thousand dollars (\$300,000), nor more than one million five hundred thousand dollars (\$1,500,000), as required by the director. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all

provisions of the law have been complied with, the director shall so certify, retain and file the articles of incorporation and shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(3) No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after such further period, not exceeding one (1) year, as may be authorized by the director upon cause shown, unless the five hundred (500) applicants hereinafter required have been secured and the organization has been completed as herein provided. The charter and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(4) Upon receipt of a preliminary certificate of authority from the director, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

(a) Actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(b) At least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;

(c) There has been submitted to the director, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

(d) It shall have been shown to the director, by sworn statement of the treasurer, or corresponding officer of such society, that at least five

hundred (500) applicants have each paid in cash at least one (1) regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least one hundred fifty thousand dollars (\$150,000). Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one (1) year, as herein provided, such premiums shall be returned to said applicants.

(5) The director may make such examination and require such further information as the director deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the director shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The director shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(6) Any incorporated society authorized to transact business in this state at the time this act becomes effective shall not be required to reincorporate.

History.

I.C., § 41-3210, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Cross References.

Acknowledgments, § 55-701 et seq.

Prior Laws.

Former § 41-3210, which comprised 1961, ch. 330, § 687, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The phrase “the effective date of this act” in the introductory paragraph refers to the effective date of S.L. 1995, Chapter 213, which was effective January 1, 1996.

The term “this act” in subsection (6) refers to S.L. 1995, Chapter 213, which is codified as §§ 41-3201 to 41-3239.

§ 41-3211. Amendments to laws. — (1) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one (1) of the methods herein specified.

(2) No amendment to the laws of any domestic society shall take effect unless approved by the director who shall approve such amendment if the director finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects and purposes of the society. Unless the director shall disapprove any such amendment within sixty (60) days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the director shall be forwarded in writing, and mailed to the secretary or corresponding officer of the society at its principal office. In case the director disapproves such amendment, the reasons therefor shall be stated in such written notice.

(3) Within ninety (90) days from the approval thereof by the director, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

(4) Every foreign or alien society authorized to do business in this state shall file with the director a duly certified copy of all amendments of, or additions to, its laws within ninety (90) days after the enactment of same.

(5) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

History.

I.C., § 41-3211, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3211, which comprised 1961, ch. 330, § 688, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3212. Institutions. — (1) A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted in [section 41-3205\(1\)\(b\), Idaho Code](#). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement but shall not be allowed as an admitted asset of such society.

(2) No society shall own or operate funeral homes or undertaking establishments.

History.

[I.C., § 41-3212](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3212, which comprised 1961, ch. 330, § 689, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3213. Reinsurance. — (1) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the director, but no such society may reinsure substantially all of its insurance in force without the written permission of the director. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after the effective date of this act, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(2) Notwithstanding the limitation in subsection (1) of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the director under [section 41-3214, Idaho Code](#).

History.

[I.C., § 41-3213](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3213, which comprised 1961, ch. 330, § 690, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The phrase “the effective date of this act” in subsection (1) refers to the effective date of S.L. 1995, Chapter 213, which was effective January 1, 1996.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-3214. Consolidations and mergers. — (1) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the director:

- (a) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;
- (b) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the director, but not earlier than December 31 next preceding the date of the contract;
- (c) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds (2/3) vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and
- (d) Evidence that at least sixty (60) days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(2) If the director finds that the contract is in conformity with the provisions of this section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each society, the director shall approve the contract and issue his certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the director of this state, or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the director of insurance of such state or territory and a certificate of such approval filed with the director.

(3) Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(4) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

History.

I.C., § 41-3214, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3214, which comprised 1961, ch. 330, § 691, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3215. Conversion of fraternal benefit society into a mutual life insurance company. — Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the applicable requirements of [section 41-2820, Idaho Code](#) (initial requirements — domestic mutuals). A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds (2/3) of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the director who may give such approval if the director finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

History.

[I.C., § 41-3215](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3215, which comprised 1961, ch. 330, § 692, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-3216. Benefits. — (1) A society may provide the following contractual benefits in any form:

(a) Death benefits;

(b) Endowment benefits; (c) Annuity benefits; (d) Temporary or permanent disability benefits; (e) Hospital, medical or nursing benefits; and (f) Monument or tombstone benefits to the memory of deceased members; and (g) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(2) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (1) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

(3) Any new or renewing society contract relating to hospital, medical or nursing benefits delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half ($\frac{1}{2}$) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

History.

I.C., § 41-3216, as added by 1995, ch. 213, § 2, p. 722; am. 2008, ch. 296, § 2, p. 827; am. 2009, ch. 125, § 3, p. 391.

STATUTORY NOTES

Prior Laws.

Former § 41-3216, which comprised 1961, ch. 330, § 693, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Amendments.

The 2008 amendment, by ch. 296, added subsection (3).

The 2009 amendment, by ch. 125, rewrote the first sentence in subsection (3), which formerly read: “Any society contract relating to hospital, medical or nursing benefits delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-one (21) years or an unmarried child who is a full-time student under the age of twenty-five (25) years and who is financially dependent upon the parent shall be permitted to remain on the parent’s or parents’ contract.”

§ 41-3217. Beneficiaries. — (1) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of five hundred dollars (\$500).

(3) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

History.

I.C., § 41-3217, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3217, which comprised 1961, ch. 330, § 694, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3218. Benefits not attachable. — No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

History.

I.C., § 41-3218, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3218, which comprised 1961, ch. 330, § 695, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3219. The benefit contract. — (1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(2) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(3) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either: (a) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or (b) in lieu of or in combination with (a), the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the

manner of the election and which alternative is to be presumed if no election is made.

(5) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(6) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the director in the manner provided for like policies issued by life and disability insurers in this state. Every life, accident and sickness, health or disability insurance certificate and every annuity certificate issued on or after one (1) year from the effective date of this act must be filed with the director and shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life and disability insurers in this state, except that a society may provide for a grace period for payment of premiums of one (1) full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium. Any filing made hereunder shall be deemed approved unless disapproved within sixty (60) days from the date of such filing.

(7) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(8) A society may specify the terms and conditions on which benefit contracts may be assigned.

History.

I.C., § 41-3219, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3219, which comprised 1961, ch. 330, § 696, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The phrase “the effective date of this act” in the second sentence in subsection (6) refers to the effective date of S.L. 1995, Chapter 213, which was effective January 1, 1996.

§ 41-3220. Nonforfeiture benefits, cash surrender values, certificate loans and other options. — (1) For certificates issued prior to one (1) year after the effective date of this act, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to the effective date of this act.

(2) For certificates issued on or after one (1) year from the effective date of this act for which reserves are computed on the commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial table or the commissioner's 1958 standard ordinary mortality table, or the commissioner's 1980 standard mortality table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

History.

I.C., § 41-3220, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3220, which comprised 1961, ch. 330, § 697, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The phrase "the effective date of this act" in subsections (1) and (2) refers to the effective date of S.L. 1995, Chapter 213, which was effective January 1, 1996.

§ 41-3221. Investments. — A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

History.

I.C., § 41-3221, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3221, which comprised 1961, ch. 330, § 698, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3222. Funds. — (1) All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(3) A society may, pursuant to resolution of its supreme governing body, establish and operate one (1) or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which subsections (2) and (4) of [section 41-3219, Idaho Code](#), shall not apply.

History.

[I.C., § 41-3222](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3222, which comprised 1961, ch. 330, § 699, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3223. Taxation. — Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment.

History.

I.C., § 41-3223, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3223, which comprised 1961, ch. 330, § 700, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3224. Valuation. — (1) Standards of valuation for certificates issued prior to one (1) year after the effective date of this act shall be those provided by the laws applicable immediately prior to the effective date of this act.

(2) The minimum standards of valuation for certificates issued on or after one (1) year from the effective date of this act shall be based on the following tables:

(a) For certificates of life insurance — the commissioner's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial mortality table, the commissioner's 1958 standard ordinary mortality table, the commissioner's 1980 standard ordinary mortality table or any more recent table made applicable to life insurers;

(b) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancellable accident and health benefits — such tables as are authorized for use by life insurers in this state.

All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(3) The director may, in his discretion, accept other standards for valuation if the director finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The director may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(4) Any society, with the consent of the director of insurance of the state of domicile of the society and under such conditions, if any, which the director may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

History.

I.C., § 41-3224, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3224, which comprised 1961, ch. 330, § 701, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The phrase “the effective date of this act” in subsections (1) and (2) refers to the effective date of S.L. 1995, Chapter 213, which was effective January 1, 1996.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-3225. Reports. — Reports shall be filed in accordance with the provisions of this section.

(1) Every society transacting business in this state shall annually, on or before the first day of March, unless for cause shown such time has been extended by the director, file with the director a true statement of its financial condition, transactions and affairs for the preceding calendar year and pay the fee specified in [section 41-3235, Idaho Code](#), for filing same. The statement shall be in general form and context as approved by the national association of insurance commissioners for fraternal benefit societies and as supplemented by additional information required by the director.

(2) As part of the annual statement herein required, each society shall, on or before the first day of March, file with the director a valuation of its certificates in force on December 31 last preceding, provided the director may, in his discretion for cause shown, extend the time for filing such valuation for not more than two (2) calendar months. Such valuation shall be done in accordance with the standards specified in [section 41-3224, Idaho Code](#). Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(3) A society neglecting to file the annual statement in the form and within the time provided by this section may be subject to a fine of one hundred dollars (\$100) for each day during which such neglect continues, and its authority to do business in this state may be suspended by the director while such default continues.

History.

[I.C., § 41-3225](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3225, which comprised 1961, ch. 330, § 702, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (1), see *<http://naic.org>*.

§ 41-3226. License. — (1) No fraternal benefit society shall transact business in this state without a license therefor issued by the director. Such a license issued under this code shall continue in force for as long as the society is entitled thereto under this chapter and until suspended or revoked by the director, or terminated at the request of the society; subject, however, to continuance of the license by the society each year by:

(a) Payment prior to March 1 of the continuation fee provided in [section 41-3235, Idaho Code](#), (fees); and

(b) Due filing by the society of its annual statement for the calendar year preceding as required under [section 41-3225, Idaho Code](#).

(2) If not so continued by the society, its license shall expire at midnight on the March 31 next following such failure of the society to continue it in force. The director shall promptly notify the society of the occurrence of any failure resulting in impending expiration of its license.

(3) The director may, in his discretion, upon the society's request made within three (3) months after expiration, reinstate a license which the society has inadvertently permitted to expire, after the society had fully cured all its failures which resulted in the expiration, and upon payment by the society of an additional fee for reinstatement specified in [section 41-3235, Idaho Code](#) (fees). Otherwise the society shall be granted another license only after filing application therefor and meeting all other requirements as for an original license.

(4) For each license the society shall pay the director the fee prescribed in [section 41-3235, Idaho Code](#).

(5) A duly certified copy or duplicate of the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

History.

[I.C., § 41-3226](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3226, which comprised 1961, ch. 330, § 703, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-3227. Examination of societies — No adverse publications. —

(1) The director, or any person he may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(2) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the director.

History.

I.C., § 41-3227, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3227, which comprised 1961, ch. 330, § 704, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3228. Foreign or alien society — Admission. — No foreign or alien society shall transact business in this state without a license issued by the director. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to transact business in this state upon filing with the director:

(1) A duly certified copy of its chapters of incorporation; (2) A copy of its bylaws, certified by its secretary or corresponding officer; (3) A power of attorney to the director as prescribed in [section 41-3234, Idaho Code](#); (4) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the director, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the director; (5) Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein; (6) Copies of its certificate forms; and

(7) Such other information as the director may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of this chapter.

History.

[I.C., § 41-3228](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3228, which comprised 1961, ch. 330, § 705, p. 645; am. 1972, ch. 164, § 6, p. 376, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3229. Injunction — Liquidation — Receivership of domestic society. — (1) When the director upon investigation finds that a domestic society:

- (a) Has exceeded its powers;
- (b) Has failed to comply with any provision of this chapter;
- (c) Is not fulfilling its contracts in good faith;
- (d) Has a membership of less than four hundred (400) after an existence of one (1) year or more; or
- (e) Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business;

the director shall notify the society of such deficiency or deficiencies and state in writing the reasons for his dissatisfaction. The director shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty (30) day period in which to comply with the director's request for correction, and if the society fails to comply the director shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(2) If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the director may commence an action to enjoin the society from transacting business or in quo warranto.

(3) The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

- (a) The director finds that the violation complained of has been corrected;

(b) The costs of such action shall have been paid by the society if the court finds that the society was in default as charged;

(c) The court has dissolved its injunction; and

(d) The director has reinstated the certificate of authority.

(4) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

(5) No action under this section shall be recognized in any court of this state unless brought by the director. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the director of insurance as such receiver.

(6) The provisions of this section relating to hearing by the director, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

History.

I.C., § 41-3229, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3229, which comprised 1961, ch. 330, § 706, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3230. Suspension, revocation or refusal of license of foreign or alien society. — (1) When the director upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

(a) Has exceeded its powers; (b) Has failed to comply with any of the provisions of this chapter; (c) Is not fulfilling its contracts in good faith; or (d) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public; the director shall notify the society of such deficiency or deficiencies and state in writing the reasons for his dissatisfaction. The director shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are [be] corrected. After such notice the society shall have a thirty (30) day period in which to comply with the director's request for correction, and if the society fails to comply, the director shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, the director may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the director that such suspension or refusal should be withdrawn or the director may revoke the authority of the society to do business in this state.

(2) Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

History.

I.C., § 41-3230, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3230, which comprised 1961, ch. 330, § 707, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Compiler's Notes.

The bracketed insertion in the first full sentence in the last paragraph of subsection (1) was added by the compiler to correct the enacting legislation.

§ 41-3231. Injunction. — No application or petition for injunction against any domestic, foreign or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the attorney general upon request of the director.

History.

I.C., § 41-3231, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Prior Laws.

Former § 41-3231, which comprised 1961, ch. 330, § 708, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3232. Licensing of agents. — Agents of societies shall be licensed in accordance with the provisions of chapter 10, title 41, Idaho Code. Except, that no such license shall be required as to members of societies which provide benefits in case of death or disability resulting solely from accident, and which do not obligate themselves to pay natural death or sick benefits, which members procure other members and receive no compensation therefor other than awards or merchandise nominal in value.

History.

I.C., § 41-3232, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3232, which comprised 1961, ch. 330, § 709, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3233. Unfair methods of competition and unfair and deceptive acts and practices. — Every society authorized to do business in this state shall be subject to the provisions of chapter 13, title 41, Idaho Code, relating to trade practices and frauds; provided however, that nothing therein shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

History.

I.C., § 41-3233, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3233, which comprised 1961, ch. 330, § 710, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3234. Service of process. — (1) Every society authorized to do business in this state shall appoint in writing the director and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in such writing that any lawful process against it which is served on such attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of such appointment, certified by the director, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

(2) Service shall only be made upon the director, or if absent, upon the person in charge of his office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the director, he shall forthwith forward one (1) of the duplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty (30) days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided.

(3) At the time of serving any process upon the director, the plaintiff or complainant in the action shall pay to the director the fee prescribed in [section 41-3235, Idaho Code](#).

History.

[I.C., § 41-3234](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3234, which comprised 1961, ch. 330, § 711, p. 645; am. 1981, ch. 49, § 1, p. 72, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3235. Fees. — (1) The director shall collect in advance from fraternal benefit societies the licenses and fees, in addition to fees connected with the licenses of agents, as otherwise provided by rule.

(2) The director shall transmit and report all fees so collected by him as provided in [section 41-406, Idaho Code](#).

History.

[I.C., § 41-3235](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3235, which comprised 1961, ch. 330, § 712, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3236. Penalties. — (1) A person who shall knowingly or willfully make any false or fraudulent statement or representation in or relating to any application for membership or for the purpose of obtaining money from or a benefit in any society, shall be guilty of a misdemeanor and upon conviction shall be fined not less than one hundred dollars (\$100) nor more than one thousand dollars (\$1,000), or imprisoned in the county jail not less than thirty (30) days nor more than one (1) year, or both.

(2) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized in this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

(3) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall upon conviction, be subject to the penalties prescribed in [section 41-117A, Idaho Code](#).

(4) Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this chapter for which a penalty is not otherwise prescribed, shall upon conviction, be subject to the penalty prescribed in [section 41-117, Idaho Code](#).

History.

[I.C., § 41-3236](#), as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3236, which comprised 1961, ch. 330, § 713, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3237. Exemption of certain societies. — (1) Nothing contained in this chapter shall be so construed as to affect or apply to:

(a) Grand or subordinate lodges of societies, orders or associations now doing business in this state which provide benefits exclusively through local or subordinate lodges;

(b) Orders, societies or associations which admit to membership only persons engaged in one (1) or more crafts or hazardous occupations, in the same or similar lines of business; and the ladies societies or ladies auxiliaries to such orders, societies or associations;

(c) Domestic societies which limit their membership to employees of a particular city, designated firm, business house or corporation which provide for a death benefit of not more than four hundred dollars (\$400) or disability benefits of not more than three hundred fifty dollars (\$350) to any person in any one (1) year, or both;

(d) Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than four hundred dollars (\$400) or for disability benefits of not more than three hundred fifty dollars (\$350) to any one (1) person in any one (1) year, or both.

(2) Any such society or association described in subparagraphs (1)(c) and (1)(d) of this section which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subparagraph (1)(d) of this section which has more than one thousand (1,000) members, shall not be exempted from the provisions of this chapter but shall comply with all requirements thereof.

(3) No society which, by the provisions of this section, is exempt from the requirements of this chapter, except any society described in subparagraph (1)(b) of this section, shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

(4) Every fraternal benefit society heretofore organized and incorporated and which provides exclusively for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay

natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions of this chapter except that the privileges thereof relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such society.

(5) The director may require from any society or association, by examination or otherwise, such information as will enable the director to determine whether such society or association is exempt from the provisions of this chapter.

(6) Societies exempted under the provisions of this section shall also be exempt from all other provisions of the insurance laws of this state.

History.

I.C., § 41-3237, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3237, which comprised 1961, ch. 330, § 714, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3238. Review. — All decisions and findings of the director made under the provisions of this chapter shall be subject to review by proper proceedings in any court of competent jurisdiction in this state.

History.

I.C., § 41-3238, as added by 1995, ch. 213, § 2, p. 722.

STATUTORY NOTES

Prior Laws.

Former § 41-3238, which comprised 1961, ch. 330, § 715, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

§ 41-3239. Other provisions applicable. — (1) Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state, not only in governmental relations with this state, but for every other purpose, and no law hereafter enacted shall apply to them, unless expressly designated therein.

(2) The following chapters and provisions of this code shall also apply to fraternal benefit societies (who for the purpose shall be deemed also to be “insurers”) to the extent so applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of such express provisions:

- (a) Chapter 1[, title 41, Idaho Code] (scope of code);
- (b) Chapter 2[, title 41, Idaho Code] (the director of insurance);
- (c) Section 41-308(2)[, Idaho Code] (general eligibility for certificate of authority), and for the purpose the annual license of a fraternal benefit society is deemed to be its “certificate of authority”;
- (d) Sections 41-1201[, Idaho Code] (representing or aiding unauthorized insurer prohibited), 41-1202[, Idaho Code] (penalty), and 41-1203[, Idaho Code] (suits by unauthorized insurer prohibited);
- (e) The following sections of chapter 18[, title 41, Idaho Code] (the insurance contract):
 - (i) Section 41-1828[, Idaho Code] (payment discharges insurer — payment to marital community);
 - (ii) Section 41-1829[, Idaho Code] (minor may give acquittance);
 - (iii) Section 41-1830[, Idaho Code] (life policy as separate property of married woman);
 - (iv) Section 41-1838[, Idaho Code] (venue of suits against insurers);
 - (v) Section 41-1839[, Idaho Code] (allowance of attorney fees in suits against insurers);

- (f) Section 41-1934[, Idaho Code] (prohibited policy plans);
- (g) Section 41-2837[, Idaho Code] (prohibited pecuniary interest of officials);
- (h) Chapter 33[, title 41, Idaho Code] (rehabilitation and liquidation);
- (i) Section 41-332[, Idaho Code] (foreign insurers exempt from corporation laws governing admission of foreign corporations);
- (j) Section 41-2141[, Idaho Code] (coordination with social security benefits);
- (k) Section 41-1927A[, Idaho Code] (standard nonforfeiture law for individual deferred annuities);
- (l) Chapter 46[, title 41, Idaho Code] (long-term care insurance); and
- (m) Chapter 54[, title 41, Idaho Code] (risk-based capital).

History.

I.C., § 41-3239, as added by 1995, ch. 213, § 2, p. 722; am. 2014, ch. 319, § 7, p. 785.

STATUTORY NOTES

Prior Laws.

Former § 41-3239, which comprised 1961, ch. 330, § 716, p. 645, was repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996.

Amendments.

The 2014 amendment, by ch. 319, added paragraph (2)(m).

Compiler's Notes.

The bracketed insertions throughout the section were added by the compiler to conform to the statutory citation style.

Section 41-1829, referred to in subsection (2)(e)(ii) of this section, was repealed by S.L. 1972, ch. 241, § 1.

Chapter 33 (Rehabilitation and Liquidation), referred to in subsection (2)(h), was repealed by S.L. 1981, ch. 249 and replaced by a new chapter 33,

title 41, Idaho Code (Insurers Supervision, Rehabilitation and Liquidation).

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 3 of S.L. 1995, ch. 213 provided that the act should be in full force and effect on January 1, 1996.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-3240 — 41-3245. Taxation — Exemptions — Penalties — Fraternal benefit society fees — Applicability of other provisions. [Repealed.]

STATUTORY NOTES

Prior Laws.

Former § 41-3244, which comprised 1961, ch. 330, § 721, p. 645; am. 1969, ch. 214, § 70, p. 625; am. 1976, ch. 72, § 2, p. 240; am. 1979, ch. 122, § 5, p. 375; am. 1980, ch. 60, § 1, p. 117, was repealed by S.L. 1984, ch. 23, § 1.

Compiler's Notes.

The following sections were repealed by S.L. 1995, ch. 213, § 1, effective January 1, 1996: § 41-3240. 1961, ch. 330, § 717, p. 645.

§ 41-3241. 1961, ch. 330, § 718, p. 645.

§ 41-3242. 1961, ch. 330, § 719, p. 645.

§ 41-3243. 1961, ch. 330, § 720, p. 645; am. 1988, ch. 169, § 2, p. 299.

§ 41-3244. **I.C., § 41-3244**, as added by 1984, ch. 23, § 6, p. 38.

§ 41-3245. 1961, ch. 330, § 722, p. 645; am. 1978, ch. 10, § 3, p. 19; am. 1981, ch. 49, § 2, p. 72; am. 1990, ch. 285, § 3, p. 796.

Chapter 33

INSURERS SUPERVISION, REHABILITATION AND LIQUIDATION

Sec.

41-3301. Construction and purpose.

41-3302. Persons covered.

41-3303. Definitions.

41-3304. Jurisdiction and venue.

41-3305. Injunctions and orders.

41-3306. Cooperations of officers, owners, and employees.

41-3307. Bonds.

41-3308. Continuation of delinquency proceedings.

41-3309. Director's summary orders and supervision proceedings.

41-3310. Court's seizure order.

41-3311. Hearings.

41-3312. Grounds for rehabilitation.

41-3313. Rehabilitation orders.

41-3314. Powers and duties of the rehabilitator.

41-3315. Actions by and against rehabilitator.

41-3316. Termination of rehabilitation.

41-3317. Grounds for liquidation.

41-3318. Liquidation orders.

41-3319. Continuance of coverage.

41-3320. Insurer — Dissolution.

41-3321. Powers of liquidator.

41-3322. Notice to creditors and others.

41-3323. Duties of agents.

41-3324. Actions by and against liquidator.

41-3325. Collection and list of assets.

41-3326. Fraudulent transfers prior to petition.

41-3327. Fraudulent transfer after petition.

41-3328. Voidable preferences and liens.

41-3329. Claims of holders of void or voidable rights.

41-3330. Setoffs.

41-3331. Assessments.

41-3332. Reinsurer's liability.

41-3333. Recovery of premiums owed.

41-3334. Domiciliary liquidator's proposal to distribute assets.

41-3335. Filing of claims.

41-3336. Proof of claim.

41-3337. Special claims.

41-3338. Special provisions for third party claims.

41-3339. Disputed claims.

41-3340. Claims of surety.

41-3341. Secured creditor's claims.

41-3342. Priority of distribution.

41-3343. Liquidator's recommendations to the court.

41-3344. Distribution of assets.

41-3345. Unclaimed and withheld funds.

41-3346. Termination of proceedings.

41-3347. Reopening liquidation.

- 41-3348. Disposition of records during and after termination of liquidation.
- 41-3349. External audit of the receiver's books.
- 41-3350. Conservation of property of foreign or alien insurers found in this state.
- 41-3351. Liquidation of property of foreign or alien insurers found in this state.
- 41-3352. Domiciliary liquidators in other states.
- 41-3353. Ancillary formal proceedings.
- 41-3354. Ancillary summary proceedings.
- 41-3355. Claims of nonresidents against insurers domiciled in this state.
- 41-3356. Claims of residents against insurers domiciled in reciprocal states.
- 41-3357. Attachment, garnishment, and levy of execution.
- 41-3358. Interstate priorities.
- 41-3359. Subordination of claims for noncooperation.
- 41-3360. Severability.

§ 41-3301. Construction and purpose. — (1) This act shall be cited as the “Idaho Insurers Supervision, Rehabilitation, and Liquidation Act.”

(2) This act shall not be interpreted to limit the powers granted the director by other provisions of the law.

(3) This act shall be liberally construed to effect the purpose stated in subsection (4) of this section.

(4) The purpose of this act is the protection of the interests of insureds, claimants, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers through:

- (a) Early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures;
- (b) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;
- (c) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;
- (d) Equitable apportionment of any unavoidable loss;
- (e) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this state; and
- (f) Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

History.

I.C., § 41-3301, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former §§ 41-3301 to 41-3337 (1961, ch. 330, §§ 723 to 758, p. 645; I.C., § 41-3337, as added by 1977, ch. 196, § 1, p. 531; 1980, ch. 274, §§ 1, 2, p. 717) were repealed by S.L. 1981, ch. 249, § 1.

Compiler's Notes.

The term “this act” at or near the beginning of each subsection refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

CASE NOTES

Cited Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987); Idaho ex rel. Soward v. United States, 858 F.2d 445 (9th Cir. 1988).

§ 41-3302. Persons covered. — The proceedings authorized by this act may be applied to:

(1) All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future.

(2) All insurers who purport to do an insurance business in this state.

(3) All insurers who have insureds resident in this state.

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this state.

(5) All nonprofit service plans and all fraternal benefit societies and beneficial societies.

(6) All title insurance companies.

History.

I.C., § 41-3302, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3302 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in the introductory paragraph refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3303. Definitions. — For the purposes of this act:

- (1) “Ancillary state” means any state other than a domiciliary state.
- (2) “Director” means the director of the department of insurance of this state.
- (3) “Creditor” is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.
- (4) “Delinquency proceeding” means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, and any summary proceeding under sections 41-3309 and 41-3310, Idaho Code. “Formal delinquency proceeding” means any liquidation or rehabilitation proceeding.
- (5) “Doing business” includes any of the following acts, whether effected by mail or otherwise:
 - (a) The issuance or delivery of contracts of insurance to persons resident in this state;
 - (b) The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;
 - (c) The collection of premiums, membership fees, assessments, or other consideration for such contracts; or
 - (d) The transaction of matters subsequent to execution of such contracts and arising out of them.
 - (e) Operating under a license or certificate of authority, as an insurer, issued by the insurance department.
- (6) “Domiciliary state” means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.
- (7) “Fair consideration” is given for property or obligation:

(a) When in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(b) When such property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

(8) “Foreign country” means any other jurisdiction not in any state.

(9) “General assets” mean all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, “general assets” include all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(10) “Guaranty association” means the Idaho insurance guaranty association created by chapter 36, title 41, Idaho Code, the Idaho life and health insurance guaranty association created by chapter 43, title 41, Idaho Code, and any other similar entity now or hereafter created by the legislature of this state for the payment of claims of insolvent insurers. “Foreign guaranty association” means any similar entities now in existence in or hereafter created by the legislature of any other state.

(11) “Insolvency” or “insolvent” means:

(a) For an insurer issuing only assessable fire insurance policies:

1. The inability to pay any obligation within thirty (30) days after it becomes payable; or

2. If an assessment be made within thirty (30) days after such date, the inability to pay such obligation thirty (30) days following the date specified in the first assessment notice issued after the date of loss.

(b) For any other insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

1. Any capital and surplus required by law for its organization; or

2. The total par or stated value of its authorized and issued capital stock.

(c) As to any insurer licensed to do business in this state as of the effective date of this act which does not meet the standard established under paragraph 2, the term “insolvency” or “insolvent” shall mean, for a period not to exceed three (3) years from the effective date of this act, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the director under provisions of the insurance law.

(d) For purposes of this subsection, “liabilities” shall include, but not be limited to, reserves required by statute or by insurance department general regulations or specific requirements imposed by the director upon a subject company at the time of admission or subsequent thereto.

(12) “Insurer” means any person who has done, purports to do, is doing or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision or conservation by any insurance director. For purposes of this act, any other persons included under [section 41-3302, Idaho Code](#), shall be deemed to be insurers.

(13) “Preferred claim” means any claim with respect to which the terms of this act accord priority of payment from the general assets of the insurer.

(14) “Receiver” means receiver, liquidator, rehabilitator, or conservator as the context requires.

(15) “Reciprocal state” means any state other than this state in which in substance and effect sections 41-3318(1), 41-3352, 41-3353 and 41-3355 through 41-3357, Idaho Code, are in force, and in which provisions are in force requiring that the director or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(16) “Secured claim” means any claim secured by mortgage, trust, deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes

claims which have become liens upon specific assets by reason of judicial process.

(17) “Special deposit claim” means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(18) “State” means any state, district, or territory of the United States and the Panama Canal Zone.

(19) “Transfer” shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

History.

I.C., § 41-3303, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3303 was repealed. See Prior Laws, § 41-3301.

Compiler’s Notes.

The phrase “the effective date of this act” in paragraph (11)(c) refers to the effective date of S.L. 1981, Chapter 249, which was effective July 1, 1981.

The term “this act” in the introductory paragraph and in subsections (12) and (13) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3304. Jurisdiction and venue. — (1) No delinquency proceeding shall be commenced under this chapter by anyone other than the director of this state and no court shall have jurisdiction to entertain, hear or determine any proceeding commenced by any other person.

(2) No court of this state shall have jurisdiction to entertain, hear or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to or relating to such proceedings other than in accordance with this chapter.

(3) In addition to other grounds for jurisdiction provided by the laws of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Idaho rules of civil procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(a) If the person served is obligated to the insurer in any way as an incident to any agency or brokerage arrangement that may exist or has existed between the insurer and the agent or broker, in any action on or incident to the obligation; or

(b) If the person served is a reinsurer who has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or

(c) If the person served is or has been an officer, manager, trustee, organizer, promoter, or person in a position of comparable authority or influence in an insurer, against which a rehabilitation or liquidation order is in effect when the action is commenced, in any action resulting from such a relationship with the insurer.

(4) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court

may enter an appropriate order to stay further proceedings on the action in this state.

(5) All actions herein authorized shall be brought in the district court for Ada county, state of Idaho.

History.

I.C., § 41-3304, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3304 was repealed. See Prior Laws, § 41-3301.

§ 41-3305. Injunctions and orders. — (1) Any receiver appointed in a proceeding under this act, may at any time apply for and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

- (a) The transaction of further business; (b) The transfer of property;
- (c) Interference with the receiver or with a proceeding under this act; (d) Waste of the insurer's assets;
- (e) Dissipation and transfer of bank accounts; (f) The institution or further prosecution of any actions or proceedings; (g) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders; (h) The levying of execution against the insurer, its assets, or its policyholders; (i) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer; or (j) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or (k) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this act.

(2) The receiver may apply to any court outside of the state for the relief described in subsection (1) of this section.

History.

I.C., § 41-3305, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3305 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in the introductory paragraph and paragraph (c) in subsection (1) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3306. Cooperations of officers, owners, and employees. — (1) Any officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the director in any proceeding under this act or any investigation preliminary to the proceeding. The term "person," as used in this section, shall include any person who exercises control directly or indirectly over activities of an insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(a) To reply promptly in writing to any inquiry from the director requesting such a reply; and

(b) To make available to the director any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody or control.

(2) No person shall obstruct or interfere with the director in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(3) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

(4) Any person included within subsection (1) of this section who fails to cooperate with the director, or any person who obstructs or interferes with the director in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order the director issued validly under this act may:

(a) Be sentenced to pay a fine not exceeding ten thousand dollars (\$10,000) or to undergo imprisonment for a term of not more than one (1) year, or both; or

(b) After a hearing, be subject to the imposition by the director, of a civil penalty not to exceed ten thousand dollars (\$10,000) and shall be subject further to the revocation or suspension of any insurance licenses issued by the director.

History.

I.C., § 41-3306, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES**Prior Laws.**

Former § 41-3306 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in subsections (1) and (4) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3307. Bonds. — In any proceeding under this act, the director and his deputies shall be responsible on their official bonds for the faithful performance of their duties. If the court deems it desirable for the protection of the assets, it may at any time require an additional bond from the director or his deputies, and such bonds shall be paid for out of the assets of the insurer as a cost of administration.

History.

I.C., § 41-3307, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3307 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in the first sentence refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3308. Continuation of delinquency proceedings. — Every proceeding heretofore commenced under the laws in effect before the enactment of this act shall be deemed to have commenced under this act for the purpose of conducting the proceeding henceforth, except that in the discretion of the director the proceeding may be continued, in whole or in part, as it would have been continued had this act not been enacted.

History.

I.C., § 41-3308, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3308 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in three places in this section refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3309. Director's summary orders and supervision proceedings.

— (1) Whenever the director has reasonable cause to believe, and determines, after a hearing held under subsection 5 [(5)] of this section, that any domestic insurer has committed or engaged in, or is about to commit or engage in, any act, practice, or transaction that would subject it to delinquency proceedings under this act, he may make and serve upon the insurer and any other persons involved, such orders as are reasonably necessary to correct, eliminate, or remedy such conduct, condition, or ground.

(2) If upon examination, or at any other time, the director has reasonable cause to believe that any domestic insurer is in such condition as to render the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance, or if such domestic insurer gives its consent, then the director shall, upon his determination: (a) Notify the insurer of his determination; and (b) Furnish to the insurer a written list of the director's requirements to abate his determination.

(3) If the director makes a determination to supervise an insurer subject to an order under subsections (1) and (2) of this section, he shall notify the insurer that it is under the supervision of the director. During the period of supervision, the director may appoint a supervisor to supervise such insurer. The order appointing a supervisor shall direct the supervisor to enforce orders issued under subsections (1) and (2) of this section and may also require that the insurer may not do any of the following things, during the period of supervision, without the prior approval of the director or his supervisor: (a) Dispose of, convey or encumber any of its assets or its business in force; (b) Withdraw from any of its bank accounts;

(c) Lend any of its funds;

(d) Invest any of its funds;

(e) Transfer any of its property;

(f) Incur any debt, obligation or liability;

(g) Merge or consolidate with another company; or (h) Enter into any new reinsurance contract or treaty.

(4) Any insurer subject to an order under the provisions of this section shall comply with the lawful requirements of the director and, if placed under supervision, shall have sixty (60) days from the date the supervision order is served within which to comply with the requirements of the director. In the event of such insurer's failure to comply within such times, the director may institute proceedings under sections 41-3312 or 41-3317, Idaho Code, to have a rehabilitator or liquidator appointed, or extend the period of supervision.

(5) The notice of hearing under subsection (1) of this section and any order issued pursuant to such subsection shall be served upon the insurer pursuant to the applicable rules of civil or administrative procedure. The notice of hearing shall state the time and place of hearing, and the conduct, condition or ground upon which the director would base his order. Unless mutually agreed between the director and the insurer, the hearing shall occur not less than ten (10) days nor more than thirty (30) days after notice is served and shall be either in Ada county or in some other place convenient to the parties to be designated by the director. The director shall hold all hearings under subsection (1) of this section privately unless the insurer requests a public hearing, in which case the hearing shall be public.

(6)(a) Any insurer subject to an order under subsection (2) of this section may request a hearing to review that order. Such a hearing shall be held as provided in subsection (5) hereof, but the request for a hearing shall not stay the effect of the order.

(b) If the director issues an order under subsection (2) of this section, the insurer may, at any time, waive a director's hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies. Subsequent to a hearing, any party to the proceedings whose interests are substantially affected shall be entitled to judicial review of any order issued by the director.

(7) During the period of supervision the insurer may request the director to review an action taken or proposed to be taken by the supervisor, specifying wherein the action complained of is believed not to be in the best interest of the insurer.

(8) If any person has violated any supervision order issued under the provisions of this section which, as applied to him was then still in effect, he shall be liable to pay a civil penalty imposed by the district court not to exceed ten thousand dollars (\$10,000).

(9) The director may apply for and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to enforce a supervision order.

(10) In the event that any person, subject to the provisions of this act, including those persons described in [section 41-3306\(1\), Idaho Code](#), shall knowingly violate any valid order of the director issued under the provisions of this section and, as a result of such violation, the net worth of the insurer shall be reduced or the insurer shall suffer loss it would not otherwise have suffered, said person shall become personally liable to the insurer for the amount of any such reduction or loss. The director or supervisor is authorized to bring an action on behalf of the insurer in the district court to recover the amount of the reduction or loss together with any costs.

History.

[I.C., § 41-3309](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3309 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term "this act" in subsections (1) and (10) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

The bracketed insertion near the beginning of subsection (1) was added by the compiler to correct the citation format.

§ 41-3310. Court's seizure order. — (1) The director may file in the district court of this state a petition alleging, with respect to a domestic insurer:

- (a) That any grounds exist that would justify a court order for a formal delinquency proceeding against an insurer under this act;
- (b) That the interests of policyholders, creditors, or the public will be endangered by delay; and
- (c) The contents of an order deemed necessary by the director.

(2) Upon a filing under subsection (1) of this section, the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the director to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business, and until further order of the court enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from transaction of its business except with the written consent of the director.

(3) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the director to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the director fails to commence a formal proceeding under this act after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this act shall ipso facto vacate the seizure order.

(4) Entry of a seizure order under the provisions of this section shall not constitute an anticipatory breach of any contract of the insurer.

(5) An insurer subject to an ex parte order under the provisions of this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than fifteen (15) days after the request. A hearing

under the provisions of this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

(6) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

History.

I.C., § 41-3310, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3310 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term "this act" in paragraph (1)(a) and subsection (3) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3311. Hearings. — In all proceedings and judicial reviews thereof under sections 41-3309 and 41-3310, Idaho Code, all records of the insurer, other documents, and all insurance department files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be subject to disclosure according to chapter 1, title 74, Idaho Code.

History.

I.C., § 41-3311, as added by 1981, ch. 249, § 2, p. 502; am. 1990, ch. 213, § 58, p. 480; am. 2015, ch. 141, § 112, p. 379.

STATUTORY NOTES

Prior Laws.

Former § 41-3311 was repealed. See Prior Laws, § 41-3301.

Amendments.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” at the end of the section.

Effective Dates.

Section 111 of S.L. 1990, ch. 213, as amended by § 16 of S.L. 1991, ch. 329, provided that §§ 3 through 45 and §§ 48 through 110 of the act should take effect July 1, 1993.

§ 41-3312. Grounds for rehabilitation. — The director may apply by petition to the district court for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one (1) or more of the following grounds:

(1) The insurer is in such condition that the further transaction of business would be hazardous, financially, to its policyholders, creditors or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the director to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the director concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management.

(6) After demand by the director under the provisions of [section 41-223, Idaho Code](#), under this act, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

(7) Without first obtaining the written consent of the director, the insurer has transferred, or attempted to transfer, in a manner contrary to chapter 38, title 41, Idaho Code, or sections 41-2856 and 41-2858, Idaho Code, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this act.

(9) Within the previous six (6) years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the director under the provisions of [section 41-3309, Idaho Code](#).

(10) The insurer has failed to pay within sixty (60) days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter except that such nonpayment shall not be a ground until sixty (60) days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the director or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the director, has failed to give an adequate explanation immediately.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in [section 41-3802, Idaho Code](#), request or consent to rehabilitation under this act.

History.

I.C., § 41-3312, as added by 1981, ch. 249, § 2, p. 502; am. 2013, ch. 266, § 12, p. 652.

STATUTORY NOTES**Prior Laws.**

Former § 41-3312 was repealed. See Prior Laws, § 41-3301.

Amendments.

The 2013 amendment, by ch. 266, updated the reference in subsection (12) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Compiler's Notes.

The term “this act” in subsections (6), (8), and (12) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3313. Rehabilitation orders. — (1) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the director and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the district court or recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(2) Any order issued under this section shall require accounting to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in its order.

(3) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer.

History.

I.C., § 41-3313, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3313 was repealed. See Prior Laws, § 41-3301.

CASE NOTES

Cited Univ. Life Ins. Co. v. Liquidator for the Univ. Life Ins. Co., 144 Idaho 751, 171 P.3d 242 (2007).

§ 41-3314. Powers and duties of the rehabilitator. — (1) The director as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under the provisions of this section, and the director may employ such counsel, clerks, and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the director, with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the director. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the director may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the director for the use of the insurance department out of the first available money of the insurer.

(2) The rehabilitator may take such action as he deems necessary or appropriate to reform and revitalize the insurer. He shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(3) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(4) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as

modified. Any plan approved under the provisions of this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(5) The rehabilitator shall have the power under sections 41-3326 and 41-3327, Idaho Code, to avoid fraudulent transfers.

History.

I.C., § 41-3314, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3314 was repealed. See Prior Laws, § 41-3301.

§ 41-3315. Actions by and against rehabilitator. — (1) Any court in this state before which any action or proceeding in which the insurer is a party or is obligated to defend a party is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for ninety (90) days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the order of rehabilitation is entered or the petition is denied.

(3) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

History.

I.C., § 41-3315, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3315 was repealed. See Prior Laws, § 41-3301.

§ 41-3316. Termination of rehabilitation. — (1) Whenever the director believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the director may petition the district court for an order of liquidation. A petition under the provisions of this subsection shall have the same effect as a petition under the provisions of [section 41-3317, Idaho Code](#). The district court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(2) The rehabilitator may at any time petition the district court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the district court finds that rehabilitation has been accomplished and that grounds for rehabilitation under the provisions of [section 41-3312, Idaho Code](#), no longer exist, it shall order that the insurer be restored to possession of its property and the control of its business. The district court may also make that finding and issue that order at any time upon its own motion.

History.

[I.C., § 41-3316](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3316 was repealed. See Prior Laws, § 41-3301.

§ 41-3317. Grounds for liquidation. — The director may petition the district court for an order directing him to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

(1) Of any ground for an order of rehabilitation as specified in [section 41-3312, Idaho Code](#), whether or not there has been a prior order directing the rehabilitation of the insurer; (2) That the insurer is insolvent; or (3) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

History.

[I.C., § 41-3317](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3317 was repealed. See Prior Laws, § 41-3301.

§ 41-3318. Liquidation orders. — (1) An order to liquidate the business of a domestic insurer shall appoint the director and his successors in office liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the district court and the recorder of deeds of the county in which its principal office or place of business is located, or, in the case of real estate, with the recorder of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(2) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in sections 41-3319 and 41-3337, Idaho Code.

(3) An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(4) At the time of petitioning for an order of liquidation, or at any time thereafter, the director, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper the court may make the declaration.

(5) Any order issued under the provisions of this section shall require accounting to the court by the liquidator. Accountings shall be at such intervals as the court specifies in its order.

History.

I.C., § 41-3318, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3318 was repealed. See Prior Laws, § 41-3301.

§ 41-3319. Continuance of coverage. — (1) All policies, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

- (a) A period of thirty (30) days from the date of entry of the liquidation orders;
- (b) The expiration of the policy coverage;
- (c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or
- (d) The liquidator has effected a transfer of the policy obligation pursuant to [section 41-3321\(1\)\(h\), Idaho Code](#).

(2) An order or liquidation under the provisions of [section 41-3318, Idaho Code](#), shall terminate coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for such period and under such terms as are provided for by any applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under the provisions of subsections (1) and (2) hereof.

History.

[I.C., § 41-3319](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3319 was repealed. See Prior Laws, § 41-3301.

§ 41-3320. Insurer — Dissolution. — The director may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time he applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the director upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent, but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

History.

I.C., § 41-3320, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3320 was repealed. See Prior Laws, § 41-3301.

§ 41-3321. Powers of liquidator. — (1) The liquidator shall have the power:

(a) To appoint a special deputy to act for him under this act, and to determine his reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator;

(b) To employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and such other personnel as he may deem necessary to assist in the liquidation;

(c) To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers and consultants with the approval of the court;

(d) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the director may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the director for the use of the insurance department out of the first available monies of the insurer;

(e) To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony after it has been correctly reduced to writing, and in connection therewith to require the production of any books, papers, records or other documents which he deems relevant to the inquiry;

(f) To collect all debts and monies due and claims belonging to the insurer, wherever located, and for this purpose:

1. To institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts;

2. To do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as he deems best; and

3. To pursue any creditor's remedies available to enforce his claims.

(g) To conduct public and private sales of the property of the insurer;

(h) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under the provisions of [section 41-3342, Idaho Code](#);

(i) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation;

(j) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation;

(k) To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party;

(l) To continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under the provisions of [section 41-3320, Idaho Code](#), he shall have the power to apply to any court in this state or elsewhere for leave to substitute himself for the insurer as plaintiff;

(m) To prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer, or any other person;

(n) To remove any or all records and property of the insurer to the offices of the director or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations;

(o) To deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions;

(p) To invest all sums not currently needed, unless the court orders otherwise;

(q) To file any necessary documents for record in the office of any recorder of deeds or records office in this state or elsewhere where property of the insurer is located;

(r) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations;

(s) To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included within [sections 41-3326 through 41-3328, Idaho Code](#);

(t) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered;

(u) To enter into agreements with any receiver or director of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states; and

(v) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this act.

(2) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon him, nor shall it exclude in any manner his right to do such other acts not herein specifically enumerated, or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

History.

I.C., § 41-3321, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3321 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in paragraphs (1)(a) and (1)(v) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3322. Notice to creditors and others. — (1) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(a) By first class mail and either by telegram or telephone to the insurance director of each jurisdiction in which the insurer is doing business;

(b) By first class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(c) By first class mail to all insurance agents of the insurer;

(d) By first class mail to all persons known or reasonably expected to have claims against the insurer, including, but not limited to, all policyholders, at their last known address as indicated by the records of the insurer and the director of the department of finance and the secretary of state; and

(e) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(2) Notice to potential claimants under the provisions of subsection (1) of this section shall require claimants to file their claims with the liquidator together with proper proofs thereof under the provisions of [section 41-3336, Idaho Code](#), on or before a date the liquidator shall specify in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(3) If notice is given in accordance with the provisions of this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

History.

[I.C., § 41-3322](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3322 was repealed. See Prior Laws, § 41-3301.

§ 41-3323. Duties of agents. — (1) Every person who receives notice in the form prescribed in [section 41-3322, Idaho Code](#), that an insurer which he represents as an agent is the subject of a liquidation order, shall within fifteen (15) days of such notice give notice of the liquidation order. The notice shall be sent by first class mail to the last address contained in the agent's records to each policyholder or other person named in any policy issued through the agent by the insurer, if he has a record of the address of the policyholder or other person. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had in his possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another. The written notice shall include the name and address of the insurer, the name and address of the agent, identification of the policy impaired and the nature of the impairment including termination of coverage, as described in [section 41-3319, Idaho Code](#). Notice by a general agent satisfies the notice requirement for any agents under contract to him. Each agent obligated to give notice under the provisions of this section shall file a report of compliance with the liquidator.

(2) Any agent failing to give notice or file a report of compliance as required in subsection (1) of this section may be subject to payment of a penalty of not more than one thousand dollars (\$1,000) and may have his license suspended, said penalty to be imposed after a hearing held by the director.

(3) The liquidator may waive the duties imposed by this section if he determines that other notice to the policyholders of the insurer under liquidation is adequate.

History.

[I.C., § 41-3323](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3323 was repealed. See Prior Laws, § 41-3301.

§ 41-3324. Actions by and against liquidator. — (1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he may intervene in the action. The liquidator may defend any action in which he intervenes under the provisions of this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation, within two (2) years or such time in addition to two (2) years as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any such action or do any such act, required of or permitted to the insurer, within a period of one hundred eighty (180) days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(3) No statute of limitations or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation

against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the petition is denied.

(4) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

History.

I.C., § 41-3324, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3324 was repealed. See Prior Laws, § 41-3301.

§ 41-3325. Collection and list of assets. — (1) As soon as practicable after the liquidation order but not later than one hundred twenty (120) days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One (1) copy shall be filed in the office of the clerk of the district court and one (1) copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(2) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(3) A submission to the court for disbursement of assets in accordance with [section 41-3334, Idaho Code](#), fulfills the requirements of subsection (1) of this section.

History.

[I.C., § 41-3325](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3325 was repealed. See Prior Laws, § 41-3301.

§ 41-3326. Fraudulent transfers prior to petition. — (1) Every transfer made or suffered and every obligation incurred by an insurer within one (1) year prior to the filing of a successful petition for rehabilitation or liquidation under this act is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this act, which is fraudulent under the provisions of this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under the provisions of [section 41-3328\(3\), Idaho Code](#).

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(3) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (1) of this section if:

(a) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and

(b) Any part of the transaction took place within one (1) year prior to the date of filing of the petition through which the receivership was commenced.

History.

I.C., § 41-3326, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3326 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in two places in subsection (1) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3327. Fraudulent transfer after petition. — (1) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(2) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(a) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred;

(b) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending;

(c) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith; and

(d) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section,

no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(3) Nothing in this act shall impair the negotiability of currency or negotiable instruments.

History.

I.C., § 41-3327, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3327 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in subsection (3) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3328. Voidable preferences and liens. —

(1)(a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one (1) year before the filing of a successful petition for liquidation under this act, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one (1) year before the filing of the successful petition for rehabilitation or within two (2) years before the filing of the successful petition for liquidation, whichever time is shorter.

(b) Any preference may be avoided by the liquidator if:

1. The insurer was insolvent at the time of the transfer;
2. The transfer was made within four (4) months before the filing of the petition;
3. The creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or
4. The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding directly or indirectly more than five per cent (5%) of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(c) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him.

Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(3)(a) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(b) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (2) of this section, if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could

not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (2) of this section, through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(4) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (2) of this section, to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one (21) days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(5) If any lien deemed voidable under subsection (1)(b) hereof has been dissolved by the furnishing of a bond or other obligation, the surety, which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this act which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(6) The property affected by any lien deemed voidable under subsections (1) and (5) of this section shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(7) The district court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under the provisions of this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an

indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien; and if the value is less than the amount for which the property is indemnified or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(8) The liability of a surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying lien nullified and voided by the liquidator, or where the property is retained under subsection (7) of this section to the extent of the amount paid to the liquidator.

(9) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for the property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

(10) If an insurer shall, directly or indirectly, within four (4) months before the filing of a successful petition for liquidation under this act, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transaction may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefit of the estate, provided that where the attorney is in a position of influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provisions of subsection (1)(b)4 of this section.

(11)(a) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is

reasonable cause to so believe if the transfer was made within four (4) months before the date of filing of this successful petition for liquidation.

(b) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (1) of this section shall be personally liable therefor and shall be bound to account to the liquidator.

(c) Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

History.

I.C., § 41-3328, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3328 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in paragraph (1)(a) and subsections (5) and (10) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3329. Claims of holders of void or voidable rights. — (1) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance, voidable under this act, shall be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty (30) days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(2) A claim allowable under subsection (1) of this section by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under [section 41-3335, Idaho Code](#), if filed within thirty (30) days from the date of the avoidance, or within the further time allowed by the court under subsection (1) hereof.

History.

[I.C., § 41-3329](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3329 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in the first sentence in subsection (a) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3330. Setoffs. — (1) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this act shall be set off and the balance only shall be allowed or paid, except as provided in subsection (2) of this section and [section 41-3333, Idaho Code](#).

(2) No setoff shall be allowed in favor of any person where: (a) The obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer; (b) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or (c) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution.

History.

[I.C., § 41-3330](#), as added by 1981, ch. 249, § 2, p. 502; am. 1996, ch. 304, § 1, p. 1000.

STATUTORY NOTES

Prior Laws.

Former § 41-3330 was repealed. See Prior Laws, § 41-3301.

Compiler's Notes.

The term “this act” in subsection (1) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3331. Assessments. — (1) As soon as practicable but not more than two (2) years from the date of an order of liquidation under [section 41-3318, Idaho Code](#), of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

- (a) The reasonable value of the assets of the insurer;
- (b) The insurer's probable total liabilities;
- (c) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and
- (d) A recommendation as to whether or not an assessment should be made and in what amount.

(2)(a) Upon the basis of the report provided in subsection (1) of this section, including any supplements and amendments thereto, the district court may levy one or more assessments against all members of the insurer who are subject to assessment.

(b) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(3) After levy of assessment under subsection (2) of this section, the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order, to show cause why the liquidator should not pursue a judgment therefor.

(4) The liquidator shall give notice of the order to show cause by publication and by first class mail to each member liable thereunder, mailed to his last known address as it appears on the insurer's records, at least twenty (20) days before the return day of the order to show cause.

(5)(a) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause

under subsection (3) hereof, the court shall make an order adjudging the member liable for the amount of the assessment against him, pursuant to subsection (3) hereof, together with costs, and the liquidator shall have a judgment against the member therefor.

(b) If on or before such return day, the member appears and serves duly verified objections upon the liquidator, the director may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the director determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(6) The liquidator may enforce any order or collect any judgment under subsection (5) of this section by any lawful means.

History.

I.C., § 41-3331, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3331 was repealed. See Prior Laws, § 41-3301.

§ 41-3332. Reinsurer's liability. — The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

History.

I.C., § 41-3332, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3332 was repealed. See Prior Laws, § 41-3301.

§ 41-3333. Recovery of premiums owed. —

(1)(a) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person.

(b) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

History.

I.C., § 41-3333, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Compiler's Notes.

As enacted, this section contained no subsection (2).

Prior Laws.

Former § 41-3333 was repealed. See Prior Laws, § 41-3301.

§ 41-3334. Domiciliary liquidator's proposal to distribute assets. —

(1) Within one hundred twenty (120) days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshaled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) Such proposal shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in [section 41-3342, Idaho Code](#), classes 1 and 2;

(b) Disbursement of the assets marshaled to date and subsequent disbursement of assets as they become available;

(c) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(d) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in [section 41-3342, Idaho Code](#), in accordance with such priorities. No bond shall be required of any such association; and

(e) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets and any other matter as the court may direct.

(3) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made

or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association, then disbursements shall be in the amount of available assets.

(4) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating such associations.

(5) Notice of such application shall be given to the association in and to the directors of the department of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least thirty (30) days prior to submission of such application to the court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the liquidator's proposal complies with subsection (2)(a) and (2)(b) of this section.

History.

I.C., § 41-3334, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3334 was repealed. See Prior Laws, § 41-3301.

§ 41-3335. Filing of claims. — (1) Proof of all claims shall be filed with the liquidator in the form required by [section 41-3336, Idaho Code](#), on or before the last day for filing specified in the notice required under [section 41-3322, Idaho Code](#), except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(2) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) The existence of the claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it;

(b) A transfer to a creditor was avoided under [sections 41-3326 through 41-3328, Idaho Code](#), or was voluntarily surrendered under [section 41-3329, Idaho Code](#), and that the filing satisfies the conditions of [section 41-3329, Idaho Code](#); and

(c) The valuation under [section 41-3341, Idaho Code](#), of security held by a secured creditor shows a deficiency, which is filed within thirty (30) days after the valuation.

(3) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

(4) The liquidator may consider any claim filed late which is not covered by subsection (2) of this section, and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to

claimants of any lower priority. This shall continue until his claim has been paid in full.

History.

I.C., § 41-3335, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3335 was repealed. See Prior Laws, § 41-3301.

§ 41-3336. Proof of claim. — (1) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(a) The particulars of the claim including the consideration given for it; (b) The identity and amount of the security on the claim; (c) The payments made on the debt, if any;

(d) That the sum claimed is justly owing and that there is not setoff, counterclaim, or defense to the claim; (e) Any right of priority of payment or other specific right asserted by the claimants; (f) A copy of the written instrument which is the foundation of the claim; and (g) The name and address of the claimant and the attorney who represents him, if any.

(2) No claim need be considered or allowed if it does not contain all the information in subsection (1) of this section, which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(3) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (1) of this section and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(4) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion need be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within four (4) months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

(5) All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

History.

I.C., § 41-3336, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3336 was repealed. See Prior Laws, § 41-3301.

§ 41-3337. Special claims. — (1) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(2) A claim may be allowed even if contingent, if it is filed in accordance with [section 41-3335, Idaho Code](#). It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(3) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(4) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under sections 41-3313 or 41-3318, Idaho Code.

History.

[I.C., § 41-3337](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Prior Laws.

Former § 41-3337 was repealed. See Prior Laws, § 41-3301.

§ 41-3338. Special provisions for third party claims. — (1) Whenever any third party asserts a cause of action against an insured of an insured in liquidation, the third party may file a claim with the liquidator.

(2) Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty (60) days after mailing of the notice required by [section 41-3322, Idaho Code](#), whichever is later, he is an unexcused late filer.

(3) The liquidator shall make his recommendations to the court under [section 41-3342, Idaho Code](#), for the allowance of an insured's claim under subsection (2) of this section after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of:

- (a) The amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expenses of defense; or
- (b) The amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(4) If several claims founded upon one (1) policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (3) of this section. If any insured's claim is subsequently reduced under subsection (3) of this section, the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(5) No claim may be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

History.

I.C., § 41-3338, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3339. Disputed claims. — (1) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or his attorney by first class mail at the address shown in the proof of claim. Within sixty (60) days from the mailing of the notice, the claimant may file his objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(2) Whenever objections are filed with the liquidator and the liquidator does not alter his denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or his attorney and to any other persons directly affected, not less than ten (10) nor more than thirty (30) days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his recommendation.

History.

I.C., § 41-3339, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3340. Claims of surety. — Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution, however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person" as used in this section is not intended to apply to a guaranty association or foreign guaranty association.

History.

I.C., § 41-3340, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3341. Secured creditor's claims. — (1) The value of any security held by a secured creditor shall be determined in one (1) of the following ways, as the court may direct:

(a) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors;
or

(b) By agreement, arbitration, compromise or litigation between the creditor and the liquidator.

(2) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

History.

I.C., § 41-3341, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3342. Priority of distribution. — The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) Class 1. The costs and expenses of administration, including, but not limited to, the following:

- (a) The actual and necessary costs of preserving or recovering the assets of the insurer;
- (b) Compensation for all services rendered in the liquidation;
- (c) Any necessary filing fees;
- (d) The fees and mileage payable to witnesses;
- (e) Reasonable attorney's fees; and
- (f) The reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(2) Class 2. All claims under policies for losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association. All claims under life policies, annuity policies, or disability or health insurance policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity.

(3) Class 3. Claims under nonassessable policies for unearned premium or other premium refunds.

(4) Class 4. Claims of the federal government not included in class 2 or class 3 above.

(5) Class 5. Debts due to employees for services performed and benefits accrued to the extent that they do not exceed one thousand dollars (\$1,000) and represent payment for services performed within one (1) year before the commencing of delinquency proceedings. Officers and directors shall not be entitled to the benefit of this priority. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(6) Class 6. Claims of general creditors and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under the policies.

(7) Class 7. Claims of any state or local government not included in class 2 or class 3 above. Claims, including those of any state or local governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection (10) of this section.

(8) Class 8. Claims filed late or any other claims other than claims under subsections (9) and (10) of this section.

(9) Class 9. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(10) Class 10. The claims of shareholders or other owners arising out of their capacity as shareholders or owners, or any other capacity except as they may be qualified in class 2 or class 6 above.

History.

I.C., § 41-3342, as added by 1981, ch. 249, § 2, p. 502; am. 1999, ch. 321, § 1, p. 820.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 1999, ch. 321 reads: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval, and shall apply to pending and future claims in existing delinquency proceedings as well as to claims in delinquency proceedings arising after the effective date of this act.”

CASE NOTES

Claims of United States.

This section is not a law regulating the “business of insurance” within the contemplation of the McCarran-Ferguson Act (15 U.S.C.S. § 1012(b)); therefore, in an action challenging the Internal Revenue Service’s priority claim against the insurers in liquidation, the Federal Insolvency Statute (31 USCS § 3713) controlled and the United States was entitled to receive full payment of the insolvents’ obligations prior to satisfaction of the obligations of other creditors. *Idaho ex rel. Soward v. United States*, 858 F.2d 445 (9th Cir. 1988), cert. denied, 490 U.S. 1065, 109 S. Ct. 2063, 104 L. Ed. 2d 628 (1989) (see 1999 amendment).

§ 41-3343. Liquidator's recommendations to the court. — (1) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may compound, compromise or in any other manner negotiate the amount for which claims will be recommended to the court except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under [section 41-3339, Idaho Code](#). As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(2) The court may approve, disapprove, or modify, the report on claims by the liquidator. Such reports as are not modified by the court within a period of sixty (60) days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to [section 41-3339, Idaho Code](#). No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

History.

[I.C., § 41-3343](#), as added by 1981, ch. 249, § 2, p. 502.

§ 41-3344. Distribution of assets. — Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

History.

I.C., § 41-3344, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3345. Unclaimed and withheld funds. — (1) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the state treasurer, and shall be paid without interest except in accordance with [section 41-3342, Idaho Code](#), to the person entitled thereto or his legal representative upon proof satisfactory to the state treasurer of his right thereto. Any amount on deposit not claimed within six (6) years from discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the state treasurer pursuant to chapter 5, title 14, Idaho Code.

(2) All funds withheld under [section 41-3337, Idaho Code](#), and not distributed shall upon discharge of the liquidator be deposited with the state treasurer and paid by him in accordance with [section 41-3342, Idaho Code](#). Any sums remaining which under [section 41-3342, Idaho Code](#), would revert to the undistributed assets of the insurer shall be transferred to the state treasurer and become the property of the state under subsection (1) hereof, unless the director in his discretion petitions the court to reopen the liquidation under [section 41-3347, Idaho Code](#).

History.

[I.C., § 41-3345](#), as added by 1981, ch. 249, § 2, p. 502; am. 2011, ch. 151, § 23, p. 414.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 151, substituted “state treasurer” for “tax collector” in the last sentence in subsection (1).

§ 41-3346. Termination of proceedings. — (1) When all assets justifying the expense of collection and distribution have been collected and distributed under this act, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are not economical to distribute, as may be deemed appropriate.

(2) Any other person may apply to the court at any time for an order under subsection (1) hereof. If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

History.

I.C., § 41-3346, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in subsection (1) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3347. Reopening liquidation. — After the liquidation proceeding has been terminated and the liquidator discharged, the director or other interested party may at any time petition the district court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

History.

I.C., § 41-3347, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3348. Disposition of records during and after termination of liquidation. — Whenever it shall appear to the director that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

History.

I.C., § 41-3348, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3349. External audit of the receiver's books. — The district court may, as it deems desirable, cause audits to be made of the books of the director relating to any receivership established under this act, and a report of each audit shall be filed with the director and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

History.

I.C., § 41-3349, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Compiler's Notes.

The term “this act” in the first sentence refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3350. Conservation of property of foreign or alien insurers found in this state. — (1) If a domiciliary liquidator has not been appointed, the director may apply to the district court by verified petition for an order directing him to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(a) Any of the grounds in [section 41-3312, Idaho Code](#); (b) That any of its property has been sequestered by official action in its domiciliary state, or in any other state; (c) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent; (d)(i) That its certificate of authority to do business in this state has been revoked or that none was ever issued; and (ii) That there are residents of this state with outstanding claims or outstanding policies.

(2) When an order is sought under subsection (1) of this section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of the district court or the recorder of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(4) The conservator may at any time petition for and the court may grant an order under [section 41-3351, Idaho Code](#), to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under [section 41-3353, Idaho Code](#), to be appointed ancillary receiver.

(5) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The

court may also make such finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs shall be assessed against such party.

History.

I.C., § 41-3350, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3351. Liquidation of property of foreign or alien insurers found in this state. — (1) If no domiciliary receiver has been appointed, the director may apply to the district court by verified petition for an order directing him to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

- (a) Any of the grounds in sections 41-3312 or 41-3317, Idaho Code; or
- (b) Any of the grounds specified in [sections 41-3350\(1\)\(b\) through \(d\), Idaho Code](#).

(2) When an order is sought under subsection (1) of this section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) If it shall appear to the court that the best interests of creditors, policyholders, and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of the district court or the recorder of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under the provisions of this section, the liquidator, under the provisions of this section, shall thereafter act as ancillary receiver under [section 41-3353, Idaho Code](#). If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under the provisions of this section, the liquidator, under the provisions of this section, may petition the court for permission to act as ancillary receiver under [section 41-3353, Idaho Code](#).

(5) On the same grounds as are specified in subsection (1) of this section, the director may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and

business over which the court will exercise jurisdiction, or any lesser part thereof that the director deems desirable for the protection of the policyholders and creditors in this state.

(6) The court may order the director, when he has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under such rules as to the liquidation of insurers under this act as are otherwise compatible with the provisions of this section.

History.

I.C., § 41-3351, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in subsection (6) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3352. Domiciliary liquidators in other states. — (1) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under [section 41-3353\(3\), Idaho Code](#), be vested by operation of law with the title to all of the assets, property, contracts, and rights of action, agents' balances, and all of the books, accounts and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts and other records of the insurer located in this state. He also shall have the right to recover all other assets of the insurer located in this state, subject to [section 41-3353, Idaho Code](#).

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the director of this state shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books, accounts and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The director of this state may petition for a conservation or liquidation order under sections 41-3350 and 41-3351, Idaho Code, or for an ancillary receivership under [section 41-3353, Idaho Code](#), or after approval by the district court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

History.

[I.C., § 41-3352](#), as added by 1981, ch. 249, § 2, p. 502.

§ 41-3353. Ancillary formal proceedings. — (1) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the director may file a petition with the district court requesting appointment as ancillary receiver in this state:

(a) If he finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver; and

(b) If the protection of creditors or policyholders in this state so requires.

(2) The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the recorder of deeds in this state imparts the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds.

(3) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(4) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (3) of this section for ancillary receivers appointed in this state.

History.

I.C., § 41-3353, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3354. Ancillary summary proceedings. — The director in his sole discretion may institute proceedings under sections 41-3339 [41-3309] through 41-3311, Idaho Code, at the request of the director or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

History.

I.C., § 41-3354, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the beginning of the section was added by the compiler to correct the enacting legislation.

§ 41-3355. Claims of nonresidents against insurers domiciled in this state. — (1) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal, states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this act, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in [section 41-3356\(2\), Idaho Code](#), with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under [section 41-3342, Idaho Code](#).

History.

[I.C., § 41-3355](#), as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Compiler's Notes.

The term “this act” in the first sentence in subsection (2) refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

§ 41-3356. Claims of residents against insurers domiciled in reciprocal states. — (1) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove his claim in this state, he shall file his claim with the liquidator in the manner provided in sections 41-3335 and 41-3336, Idaho Code. The ancillary receiver shall make his recommendation to the court as under [section 41-3343, Idaho Code](#). He shall also arrange a date for hearing if necessary under [section 41-3339, Idaho Code](#), and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty (40) days prior to the date set for hearing. If the domiciliary liquidator, within thirty (30) days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

History.

[I.C., § 41-3356](#), as added by 1981, ch. 249, § 2, p. 502.

§ 41-3357. Attachment, garnishment, and levy of execution. —
During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

History.

I.C., § 41-3357, as added by 1981, ch. 249, § 2, p. 502.

§ 41-3358. Interstate priorities. — (1) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(3) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with [section 41-3341, Idaho Code](#), in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

History.

[I.C., § 41-3358](#), as added by 1981, ch. 249, § 2, p. 502.

§ 41-3359. Subordination of claims for noncooperation. — If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under [section 41-3342\(7\), Idaho Code](#).

History.

[I.C., § 41-3359](#), as added by 1981, ch. 249, § 2, p. 502.

§ 41-3360. Severability. — If any provision of this act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the act and the application of such provision to other persons or circumstances shall not be affected thereby.

History.

I.C., § 41-3360, as added by 1981, ch. 249, § 2, p. 502.

STATUTORY NOTES

Compiler's Notes.

The term “this act” near the beginning of the section refers to S.L. 1981, Chapter 249, which is compiled as §§ 41-3301 to 41-3360.

Chapter 34

HOSPITAL AND PROFESSIONAL SERVICE CORPORATIONS

Sec.

41-3401. Scope of chapter.

41-3402. Purpose and interpretation.

41-3403. Definitions.

41-3404. Provisions exclusive.

41-3404A, 41-3404B. Application to dental service corporation.
[Repealed.]

41-3405. Incorporation — Certificate of authority required.

41-3406. Incorporation — Laws applicable — Approval of articles of incorporation — Amendment.

41-3407. Name of corporation.

41-3408. Qualifications for certificate of authority.

41-3409. Application for certificate of authority.

41-3410. Issuance or refusal of certificate of authority.

41-3411. Continuance or expiration of certificate of authority.

41-3412. Suspension or revocation of certificate of authority.

41-3413. Services and benefits which may be provided professional service corporations.

41-3414. Services and benefits which may be provided — Hospital service corporations.

41-3414A. Services provided by pharmaceutical service corporation.
[Repealed.]

41-3415. Professional service agreements.

41-3415A. Pharmacists' service agreements.

41-3416. Hospital service agreements.

41-3417. Subscriber's contracts.

41-3418. Service agreements and subscriber's contracts must provide substantial service benefits.

41-3419. Filing and approval of agreements and contracts.

41-3420. Charges and rates.

41-3421. Reserves.

41-3422. Surplus fund.

41-3423. Investments.

41-3424. Records and accounts.

41-3425. Annual statement.

41-3426. Examination.

41-3427. Taxation and annual report.

41-3428. Joint operations.

41-3429. Combined corporation.

41-3430. Contracts covering workmen's [worker's] compensation risks.

41-3431. Annual adjustment of service payments — Disposition of excess funds.

41-3432. Fidelity bond.

41-3433. Service corporation fees.

41-3434. Other provisions applicable.

41-3435. Producer licensing.

41-3436. Dependent's coverage — Dependent's termination of coverage, disability and dependency proof and application.

41-3437. Required provisions — Infants.

41-3438. Complications of pregnancy.

41-3439. Limitation of benefits for elective abortions.

41-3440. Services provided by governmental entities.

41-3441. Mammography coverage.

41-3442. Health insurance coverage for dependent children. [Repealed.]

41-3443. Best price — Most favored nations clause prohibited.

41-3444. Contracts with providers of dental services.

§ 41-3401. Scope of chapter. — (1) This chapter shall apply to every individual, person, firm, corporation, association, or organization of any kind hereafter engaging or purporting to engage in the provision of all or part of any health care service, as hereinafter defined, for its subscribers in exchange for periodic prepayments in identifiable amount by or as to such subscribers.

(2) This chapter does not apply as to:

(a) Insurers or fraternal benefit societies authorized to transact the kind of insurance involved pursuant to other chapters of this code.

(b) Fraternal and other organizations exempted under [section 41-3242 \[41-3237\] Idaho Code](#), from the provisions of chapter 32[, title 41, Idaho Code] of this code.

(c) Health care services provided by an employer to his employees and their dependents, with or without contribution to the costs thereof by such employees, through health care service facilities owned, employed, or controlled by the employers.

(d) Contracts between employers and physicians or hospitals, relative to the care and treatment of employees of such employers, which contracts are subject to the jurisdiction of the industrial commission of Idaho.

(e) Infrequent instances of prepayment by or for the patient direct to the licensee or hospital for specific services thereafter rendered to such patient by such licensee or hospital.

History.

1961, ch. 330, § 759, p. 645; am. 1971, ch. 252, § 1, p. 1008.

STATUTORY NOTES

Cross References.

Consent to hospital, medical, dental or surgical care, treatment or procedures, § 39-4501 et seq.

Life and Health Insurance Guaranty Association Act, § 41-4301 et seq.

Compiler's Notes.

Section 41-3242, referred to in paragraph (2)(b) of this section, was repealed by S.L. 1995, ch. 213, § 1. S.L. 1995, ch. 213, § 2 enacted § 41-3237 with substantially similar language.

The bracketed insertion near the end of paragraph (2)(b) was added by the compiler to conform to the statutory citation style.

The name “industrial accident board” has been changed to “industrial commission” on authority of S.L. 1971, ch. 124, § 3 (§ 72-502).

CASE NOTES

Cited *Smith v. Idaho Hosp. Serv., Inc.*, 89 Idaho 499, 406 P.2d 696 (1965); *State v. Gardiner*, 127 Idaho 156, 898 P.2d 615 (Ct. App. 1995).

RESEARCH REFERENCES

ALR. — Right of “Blue Cross” or “Blue Shield,” or similar hospital or medical service organization to be subrogated to certificate holder’s claims against tortfeasor. 73 A.L.R.3d 1140.

§ 41-3402. Purpose and interpretation. — (1) It is the purpose of this chapter to regulate in the public interest the formation and operation of prepaid health care service organizations, in order that such services may be made available upon a basis of fair and equitable contracts through state-licensed nonprofit organizations meeting reasonable standards as to administration, reserves, and financial soundness.

(2) The provisions of this chapter shall be liberally interpreted to effectuate the purpose hereinabove declared.

History.

1961, ch. 330, § 760, p. 645.

CASE NOTES

In General.

Provision in hospital and medical service insurance certificate excluding coverage of injuries resulting from torts for which a third person makes settlement or is responsible was not void as against public policy and, where insured actually recovered from tortfeasor, barred recovery on the certificate. *Smith v. Idaho Hosp. Serv., Inc.*, 89 Idaho 499, 406 P.2d 696 (1965).

§ 41-3403. Definitions. — For the purposes of this chapter:

(1) “Health care service” means any service rendered to an individual for diagnosis, relief, or treatment of any injury, ailment or bodily condition.

(2) “Service corporation” means a corporation providing all or part of one or more health care services for subscribers thereto in exchange for periodic prepayments in identifiable amount by or as to such subscribers.

(3) A “professional service corporation” is one so providing principally health care services by one or more categories of participant licensees, as defined in subsection (9) of this section. Such a service corporation may also provide for materials customarily dispensed or furnished in connection with the services of the licensee.

(4) A “hospital service corporation” is one so providing principally hospital services.

(5) “Service agreement” is a contract between a service corporation and a licensee or hospital under which the licensee or hospital agrees to render all or part of one or more health care services to subscribers of the service corporation.

(6) “Subscriber’s contract” is that between the service corporation and its subscriber under which all or part of one or more health care services is to be rendered to or on behalf of the subscriber by a licensee or hospital that has entered into a service agreement with such corporation covering such services.

(7) “Participant hospital” is one which has entered into a service agreement with a service corporation.

(8) “Participant licensee” is one who has entered into a service agreement with a service corporation.

(9) “Licensee” is an individual while duly licensed by the state of Idaho to practice in any one or more of the following categories of health care service professions:

(a) Chiropractor;

- (b) Dentist;
- (c) Optometrist;
- (d) Osteopath;
- (e) Pharmacist;
- (f) Physician and surgeon, of either medicine and surgery or of osteopathic medicine and surgery; and
- (g) Podiatrist.

History.

1961, ch. 330, § 761, p. 645; am. 1965, ch. 46, § 1, p. 70; am. 1967, ch. 91, § 1, p. 194; am. 1967, ch. 399, § 1, p. 1194; am. 1969, ch. 36, § 1, p. 86; am. 1971, ch. 252, § 2, p. 1008.

CASE NOTES

Cited Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987); State v. Gardiner, 127 Idaho 156, 898 P.2d 615 (Ct. App. 1995).

§ 41-3404. Provisions exclusive. — No provision of this code shall apply to any such health care service corporation unless contained or referred to in this chapter.

History.

1961, ch. 330, § 762, p. 645.

CASE NOTES

Cited Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

**§ 41-3404A, 41-3404B. Application to dental service corporation.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

These sections, comprising I.C., § 41-3404A, as added by 1967, ch. 399, § 2, p. 1194, and I.C., § 41-3404B, as added by 1969, ch. 36, § 2, p. 86, were repealed by S.L. 1971, ch. 252, § 18, p. 1008.

§ 41-3405. Incorporation — Certificate of authority required. — No person otherwise subject to this chapter shall engage or purport to engage in the provision of any part or all of any health care service for its subscribers in exchange for periodic prepayments in identifiable amount unless it is a service corporation heretofore or hereafter incorporated under the laws of Idaho, and currently authorized as such a service corporation under a certificate of authority issued by the director pursuant to the provisions of this chapter.

History.

1961, ch. 330, § 763, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3406. Incorporation — Laws applicable — Approval of articles of incorporation — Amendment. — (1) A service corporation shall be formed as a nonprofit, nonstock professional service corporation consistent with the applicable requirements of this chapter under the statutes of Idaho governing the formation of nonprofit, nonstock corporations in general. The articles of incorporation shall specify the category or categories of participant licensee services to be provided by a professional service corporation; provided however, after December 31, 1994, no service corporation, whether a professional service corporation or a combined hospital and professional service corporation, shall be formed that provides in its articles of incorporation for physicians or surgeons as participant licensees, nor shall any existing service corporation of any kind thereafter amend its articles to provide for physicians or surgeons as participant licensees.

(2) Before the articles of incorporation of any such proposed corporation hereafter formed are filed with the secretary of state, they shall be submitted to the director, and the secretary of state shall not file the articles unless the director's approval is indorsed thereon. The director shall so approve the articles unless he finds, after reference of such articles to the attorney general, that they do not comply with law. If not so approved, the director shall return the proposed articles of incorporation to the incorporators together with his written statement of the particulars of the reasons for nonapproval.

(3) No amendment of the articles of incorporation of any service corporation shall be filed with the secretary of state unless it is first submitted to and approved by the director, and bears the director's approval indorsed thereon. The director shall so approve the amendment unless he finds, after reference of such amendment to the attorney general, that it was not lawfully adopted or that the articles of incorporation as so amended would be unlawful. If not so approved, the director shall return the proposed amendment to the corporation together with his written statement of the particulars of the reasons for nonapproval.

(4) Such a service corporation heretofore or hereafter formed or converted to a nonprofit mutual insurer pursuant to statute, if within its corporate powers as stated in its articles of incorporation, may also operate as a health maintenance organization and exercise all of the powers and fulfill all applicable requirements under house bill 394, second regular session, forty-second Idaho legislature. If the corporation is to operate concurrently as both a service corporation and a health maintenance organization, its health maintenance organization operations may be conducted through a separate division or department, which division or department shall operate and be treated as a separate entity for the purpose of such laws.

History.

1961, ch. 330, § 764, p. 645; am. 1967, ch. 399, § 3, p. 1194; am. 1969, ch. 36, § 3, p. 86; am. 1971, ch. 252, § 3, p. 1008; am. 1974, ch. 177, § 32, p. 1444; am. 1994, ch. 78, § 3, p. 173.

STATUTORY NOTES

Cross References.

Nonprofit corporations, § 30-30-101 et seq.

Professional service corporations, § 30-21-901.

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

House Bill 394, second regular session, forty-second Idaho legislature, referred to in subsection (4), is S.L. 1974, Chapter 177, which is codified as §§ 41-3406, 41-3901, 41-3902, 41-3904 to 41-3906, 41-3909 to 41-3911, and 41-3914 to 41-3922.

Effective Dates.

Section 7 of S.L. 1994, ch. 78 provided: “An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2 and 7 of this act shall be in full force and effect on and after passage and approval,

and Sections 3, 4, 5 and 6 of this act shall be in full force and effect on and after January 1, 1995.”

§ 41-3407. Name of corporation. — No service corporation shall have or use a corporate or business name which includes the words “insurance”, “casualty”, “surety”, “health and accident”, “mutual”, or other terms descriptive of an insurer or insurance business. No service corporation shall have or use a name so similar to that of any other corporation transacting business in this state when such service corporation was formed as would tend to confuse or mislead the public.

History.

1961, ch. 330, § 765, p. 645.

§ 41-3408. Qualifications for certificate of authority. — The director shall not issue or permit to exist a certificate of authority to be or act as a service corporation, as to any corporation not fulfilling the following qualifications:

(1) Must be incorporated as provided in [section 41-3406, Idaho Code](#), as a professional service corporation.

(2) Must intend to and actually conduct its business in good faith as a nonprofit corporation.

(3) Must have in force service agreements with participant licensees located in the areas of the subscribers' residences convenient as to location and sufficient in numbers, capacity and facilities reasonably to furnish respective categories of health care services then provided or proposed to be provided by the corporation to its subscribers. Said professional service corporation shall be ready and willing at all times to enter into service agreements with all licensees of the category or categories specified in its articles of incorporation who are qualified under the laws of the state of Idaho and who desire to become participant licensees of said corporation and who practice within the general area served by said professional service corporation.

(4) If a newly formed corporation, it must possess sufficient available working funds to pay all reasonably anticipated cost of acquisition of new business and operating expenses, other than payment for professional services, for a period of not less than the six (6) months next following the date of issuance of the certificate of authority, if issued.

(5) Nothing in this section shall preclude a service corporation from refusing to contract with a health care licensee who is unqualified or who does not meet the terms and conditions of the participating licensee contract of the service corporation or from terminating or refusing to renew the contract of a participating health care licensee who is unqualified or who does not comply with, or who refuses to comply with, the terms and conditions of the participating health care licensee contract including, but not limited to, practice standards and quality requirements. The contract

shall provide for written notice to the participating health care licensee setting forth any breach of contract for which the service corporation proposes that the contract be terminated or not renewed and shall provide for a reasonable period of time for the participating health care licensee to cure such breach prior to termination or nonrenewal. If the breach has not been cured within such period of time the contract may be terminated or not renewed. Provided however, that if the breach of contract for which the service corporation proposes that the contract be terminated or not renewed is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, the contract may be terminated or not renewed immediately.

(6) Every service corporation issuing benefits pursuant to this chapter shall establish a grievance system for licensees. Such grievance system shall provide for arbitration according to chapter 9, title 7, Idaho Code, or for such other system which provides reasonable due process provisions for the resolution of grievances and the protection of the rights of the parties.

(7) Must fulfill all other applicable requirements of this chapter.

History.

1961, ch. 330, § 766, p. 645; am. 1965, ch. 46, § 2, p. 70; am. 1967, ch. 91, § 2, p. 194; am. 1967, ch. 399, § 4, p. 1194; am. 1969, ch. 36, § 4, p. 86; am. 1971, ch. 252, § 4, p. 1008; am. 1994, ch. 78, § 4, p. 173; am. 1994, ch. 275, § 2, p. 853; am. 2007, ch. 90, § 22, p. 246.

STATUTORY NOTES

Amendments.

This section was amended by two 1994 acts which appear to be compatible and have been compiled together.

The 1994 amendment, by ch. 78, § 4, in subdivision (1), deleted “or as a hospital service corporation, or as a combined professional and hospital service corporation” following “professional service corporation”; deleted former subdivision (3); redesignated former subdivisions (4), (5) and (6) as subdivisions (3), (4), and (5) (subdivision (5), due to the amendments by ch. 275, has been compiled as [(7)] (8) — see below); at the beginning of subdivision (3), substituted “Must” for “If a professional service

corporation, it must”; and in subdivision (4), deleted “hospital or” preceding “professional services”.

The 1994 amendment, by ch. 275, § 2, added subdivisions (6) and (7), (compiled as [(5)](6) and [(6)](7), respectively); and redesignated former subdivision (6) as subdivision (8) (compiled as [(7)] (8)). The bracketed subdivision designations were added by the compiler to temporarily maintain consecutive numbering in light of the conflicting subdivision designation amendments to this section. These redesignations were made permanent by S.L. 2007, ch. 90, § 22.

The 2007 amendment, by ch. 90, redesignated former subsections (6) through (8) as (5) through (7).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 7 of S.L. 1994, ch. 78 provided: “An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2 and 7 of this act shall be in full force and effect on and after passage and approval, and Sections 3, 4, 5 and 6 of this act shall be in full force and effect on and after January 1, 1995.”

§ 41-3409. Application for certificate of authority. — (1) Application for a certificate of authority to transact business as a service corporation shall be made to the director, on forms as prepared and furnished by the director and requiring such information relative to the applicant, its directors, officers, and affairs as the director may reasonably require consistent with this chapter.

(2) The application shall be accompanied by such of the following documents as may not already be on file with the director:

- (a) One (1) copy of the applicant's articles of incorporation and of all amendments thereto, certified by the secretary of state;
- (b) One (1) copy of the applicant's bylaws, certified by its corporate secretary;
- (c) One (1) copy of each form of service agreement entered into or proposed to be entered into with participant licensees, together with a list showing the name, residence and office addresses, and date of execution of the service agreement by each such licensee;
- (d) A copy of each form of subscriber's contract proposed to be offered;
- (e) A schedule of the rates proposed to be charged subscribers;
- (f) A financial statement of the applicant as of a date not more than thirty (30) days before the filing of the application, showing among other things the amount of working funds available to the applicant, the source of such funds, and accompanied by a copy of the agreement under which any such funds were contributed to or provided for the applicant; and
- (g) A copy of any other relevant document reasonably requested by the director.

(3) At time of filing the application the applicant shall pay to the director the application fee and the fee for issuance of the certificate of authority as specified in [section 41-3433, Idaho Code](#), (fee schedule).

History.

1961, ch. 330, § 767, p. 645; am. 1967, ch. 399, § 5, p. 1194; am. 1971, ch. 252, § 5, p. 1008; am. 1994, ch. 78, § 5, p. 173.

STATUTORY NOTES

Compiler's Notes.

The words in parentheses so appeared in the law as enacted.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 7 of S.L. 1994, ch. 78 provided: “An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2 and 7 of this act shall be in full force and effect on and after passage and approval, and Sections 3, 4, 5 and 6 of this act shall be in full force and effect on and after January 1, 1995.”

§ 41-3410. Issuance or refusal of certificate of authority. — (1) If after the application for certificate of authority is completed the director finds that the applicant is fully qualified for a certificate of authority in accordance with the provisions of this chapter, and that the service agreements, subscriber's contracts, and schedule of rates are in compliance with the applicable provisions of this chapter, he shall issue to the applicant a certificate of authority as a professional service corporation.

(2) If the director does not so find, he shall refuse to issue a certificate of authority and shall give the applicant written notice thereof setting forth the particulars of the reasons for such refusal.

(3) The director shall either issue or refuse to issue the certificate of authority within a reasonable time after the filing and completion of application therefor.

History.

1961, ch. 330, § 768, p. 645; am. 1967, ch. 399, § 6, p. 1194; am. 1971, ch. 252, § 6, p. 1008; am. 1994, ch. 78, § 6, p. 173; am. 2001, ch. 85, § 9, p. 211.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 7 of S.L. 1994, ch. 78 provided: "An emergency existing therefor, which emergency is hereby declared to exist, Sections 1, 2 and 7 of this act shall be in full force and effect on and after passage and approval, and Sections 3, 4, 5 and 6 of this act shall be in full force and effect on and after January 1, 1995."

§ 41-3411. Continuance or expiration of certificate of authority. —

(1) A certificate of authority issued to a service corporation shall continue in force as long as the corporation is entitled thereto under this chapter, and until suspended or revoked by the director or terminated at the request of the corporation; subject, however, to continuance of the certificate by the corporation each year by:

(a) Payment prior to March 1 of the continuation fee provided in [section 41-3433, Idaho Code](#), (fee schedule); and (b) Due filing by the service corporation of its annual statement for the calendar year preceding as required under [section 41-3425, Idaho Code](#).

(2) If not so continued by the service corporation, its certificate of authority shall expire as at midnight on the May 31 next following such failure of the service corporation to continue it in force. The director shall promptly notify the service corporation of the occurrence of any failure resulting in impending expiration of its certificate of authority.

History.

1961, ch. 330, § 769, p. 645; am. 1971, ch. 252, § 7, p. 1008.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words in parentheses so appeared in the law as enacted.

§ 41-3412. Suspension or revocation of certificate of authority. — (1) The director shall suspend or revoke the certificate of authority of any service corporation which he finds, after a hearing thereon, is no longer qualified therefor under the provisions of this chapter.

(2) The director may, in his discretion, after a hearing thereon suspend or revoke the certificate of authority for any violation by the service corporation of any provision of this chapter for which mandatory suspension or revocation is not required under subsection (1) above, or on any applicable ground set forth in section 41-327[, Idaho Code] (suspension, revocation of certificate of authority, discretionary and special grounds).

(3) No service corporation shall, while its certificate of authority is suspended or revoked, transact any business as a service corporation other than that necessary and incidental to the discharge of its contracts and agreements outstanding on the day such suspension or revocation became effective. The corporation shall not, after the revocation of its certificate of authority solicit or issue any new subscriber's contracts.

History.

1961, ch. 330, § 770, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertion near the end of subsection (2) was added by the compiler to conform to the statutory citation style.

The words in parentheses so appeared in the law as enacted.

§ 41-3413. Services and benefits which may be provided professional service corporations. — (1) A professional service corporation shall have the right to provide to its subscribers part or all of the following services and benefits only:

- (a) Professional services furnished to the subscriber by one or more specified categories of participant licensees, as such categories are referred to in [section 41-3403\(9\), Idaho Code](#), and subject to the requirements of section 41-3408(4)[(3)], Idaho Code, (qualifications for authority) as to each such category;
- (b) Indemnity in reasonable amount with respect to professional services and drugs (under subscribers' contracts providing for services of participant licensee pharmacists) furnished to the subscriber by nonparticipant licensees of the same category or categories as participant licensees of the service corporation, but subject to section 41-3408(4) [(3)], Idaho Code, (qualifications for authority);
- (c) Indemnity in reasonable amount with respect to hospital services furnished the subscriber while under the care and treatment of a licensee entitled to practice in such hospital;
- (d) Indemnity in reasonable amount with respect to appliances, prosthetics, and similar devices and replacements, and ambulance, x-ray, physiotherapy, and similar services; and
- (e) Indemnity in reasonable amounts with respect to services rendered to the subscriber by licensees of a category or categories specified in the subscriber's contract including any category of licensee defined in [section 41-3403\(9\), Idaho Code](#), or rendered by other persons specified in the subscriber's contract, duly licensed by the state to engage in any health care profession or practice. The portion of the total charges to subscribers for such coverage as is authorized by this subsection (e) shall not exceed one-third (1/3) of the total charges to all subscribers made by the service corporation for all services and benefits rendered in any calendar year.

(2) This section shall not be deemed to prohibit such a corporation from acting as compensated servicing agent as to health care services to be provided by any public agency, or under agreements between other parties not solicited by such corporation.

History.

1961, ch. 330, § 771, p. 645; am. 1971, ch. 252, § 8, p. 1008.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in paragraphs (1)(a) and (1)(b) were added by the compiler to account for the amendment of § 41-3408 by S.L. 1994, ch. 98, § 4.

The words in parentheses so appeared in the law as enacted.

§ 41-3414. Services and benefits which may be provided — Hospital service corporations. — (1) A hospital service corporation shall have the right to provide to its subscribers part or all of the following services and benefits only:

- (a) Hospital services furnished to the subscriber by participant hospitals;
- (b) Indemnity in reasonable amount with respect to hospital services furnished to the subscriber by nonparticipant hospitals, but subject to section 41-3408(3)[, Idaho Code] (qualifications for authority); and (c) Indemnity in reasonable amount for other health care services, as defined in section 41-3403(1)[, Idaho Code], but in no event shall such indemnity benefits be provided of a value in excess of seventy-five percent (75%) of the premium charged for hospital service and hospital indemnity benefits.

(2) This section shall not be deemed to prohibit such a corporation from acting as compensated servicing agent as to health care services to be provided by any public agency, or under agreements between other parties not solicited by such corporation.

History.

1961, ch. 330, § 772, p. 645.

STATUTORY NOTES

Compiler's Notes.

Subsection (3) of § 41-3408, referred to in paragraph (1)(b), was deleted from the Idaho Code by S.L. 1994, ch. 78, § 4.

The bracketed insertions in paragraphs (1)(b) and (1)(c) were added by the compiler to conform to the statutory citation style.

The words in parentheses so appeared in the law as enacted.

Section 15 of S.L. 1967, ch. 399 read: “Nothing in this act shall be construed as prohibiting hospital service corporations from contracting to provide pharmaceutical services and drugs to subscribers as a necessary incident of hospital care.”

Idaho Code § 41-3414A

§ 41-3414A. Services provided by pharmaceutical service corporation. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-3414A, as added by 1967, ch. 399, § 7, p. 1194, was repealed by S.L. 1971, ch. 252, § 18, p. 1008.

§ 41-3415. Professional service agreements. — (1) A professional service corporation shall enter into service agreements with only licensees duly licensed by the state of Idaho.

(2) Each such service agreement shall require the participant licensees to furnish to subscribers of the service corporation the professional services which are, under the subscriber's contract, to be furnished by participant licensees; and this obligation so to furnish such service, as provided for in the subscriber's contract, shall be a direct obligation of the participant licensees to the subscribers as well as to the service corporation.

(3) Each such service agreement shall further effectively provide in substance that:

(a) The participant licensee shall be compensated for services rendered to a subscriber in accordance with a prescribed formula or a schedule of fees contained in the agreement or attached to and made a part of the agreement, and that the licensee shall not request or receive from the service corporation any compensation for such services which is not in accord with such formula or schedule.

(b) Compensation for services may be prorated and settled under the circumstances and in the manner referred to in [section 41-3431, Idaho Code](#).

(c) If the participant licensee withdraws from the service agreement, such withdrawal shall not be effective as to any subscriber's contract in force on the date of such withdrawal until the termination of such subscriber's contract or the next following anniversary of such subscriber's contract, whichever date is the earlier.

(4) The proposed form of any such service agreement shall be filed with the director and be subject to his approval, as provided in [section 41-3419, Idaho Code](#).

(5) This section shall not apply as to participant pharmacists.

History.

1961, ch. 330, § 773, p. 645; am. 1971, ch. 252, § 9, p. 1008.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 16 of S.L. 1967, ch. 399 read: “Nothing in this act shall be construed to prohibit medical service corporations from contracting to provide drugs as a necessary incident of other medical services performed in a participant physician’s office or in the subscriber’s home.”

§ 41-3415A. Pharmacists' service agreements. — (1) With respect to services of participant licensee pharmacists, the service agreement shall require the participant pharmacist to furnish to subscribers the pharmaceutical services and drugs which are, under the subscriber's contract, to be furnished by participant pharmacists; and his obligation so to furnish such services and drugs as provided for in the subscriber's contract, shall be a direct obligation of the participant pharmacist to the subscribers as well as to the service corporation.

(2) Each such service agreement shall further effectively provide in substance that:

(a) The participant pharmacist shall be compensated for services rendered and drugs furnished to a subscriber in accordance with a schedule of fees contained in the agreement or attached to and made a part of the agreement, and the pharmacist shall not request or receive from the service corporation or the subscriber any compensation for such services and drugs which is not in accord with such schedule. The subscriber may be required by the subscriber's contract to pay a fixed fee to the participant pharmacist for each prescription as a prerequisite to receiving drugs or services from the participant pharmacist.

(b) Compensation for services may be prorated and settled under the circumstances and in the manner referred to in [section 41-3431, Idaho Code](#).

(c) If the participant pharmacist withdraws from the agreement, such withdrawal shall not be effective as to any subscriber's contract in force on the date of such withdrawal until the termination of such subscriber's contract or the next following anniversary of such subscriber's contract, whichever date is the earlier.

(3) The proposed form of any such service agreement shall be filed with the director and be subject to his approval, as provided in [section 41-3419, Idaho Code](#).

History.

I.C., § 41-3415A, as added by 1967, ch. 399, § 8, p. 1194; am. 1971, ch. 252, § 10, p. 1008.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3416. Hospital service agreements. — (1) A hospital service corporation shall enter into service agreements with only hospitals duly approved or licensed by the state of Idaho.

(2) Each such service agreement shall require the participant hospital to furnish to subscribers of the service corporation the hospital services which are, under the subscriber's contract, to be furnished by participant hospitals; and this obligation so to furnish such service, as provided for in the subscriber's contract, shall be a direct obligation of the participant hospitals to the subscribers as well as to the service corporation.

(3) Each such service agreement shall further effectively in substance provide that:

(a) The participant hospital shall be compensated for services rendered to a subscriber in accordance with a schedule of charges contained in the agreement or attached to and made a part of the agreement, and that the hospital shall not request or receive from the service corporation any compensation for such services which is not in accord with such schedule.

(b) Compensation for services may be prorated and settled under the circumstances and in the manner referred to in section 41-3431[, Idaho Code].

(c) If the participant hospital withdraws from the agreement, such withdrawal shall not be effective as to any subscriber's contract in force on the date of such withdrawal until the termination of the subscriber's contract or the next following anniversary of the subscriber's contract, whichever date is the earlier.

(4) The service corporation shall terminate the service agreement as to a particular participant hospital, in addition to other bases of termination provided for in the agreement, if it is determined that the hospital has knowingly charged or attempted to charge the service corporation for any service not actually rendered, or has knowingly violated any material provision of the service agreement.

(5) The proposed form of any such service agreement and of any standard riders and endorsements thereto shall be filed with the director and be subject to his approval, as provided in section 41-3419[, Idaho Code].

History.

1961, ch. 330, § 774, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions at the ends of paragraph (3)(b) and subsection (5) were added by the compiler to conform to the statutory citation style.

§ 41-3417. Subscriber's contracts. — (1) Each subscriber's contract hereafter issued by a service corporation shall constitute a direct obligation of the participant licensees and/or participant hospitals to render the professional or hospital services, as the case may be, as agreed to be rendered by such participants in the subscriber's contract.

(2) Each such subscriber's contract or certificate shall in adequate detail set forth provisions from which can be readily determined:

(a) The services to which the subscriber is entitled from participant licensees and/or participant hospitals, as the case may be;

(b) The benefits, if any, to which the subscriber is entitled on an indemnity basis, consistent with sections 41-3413 and 41-3414, Idaho Code, and with this chapter;

(c) The periodic subscription charge, rate or fee payable by or as to the subscriber; or, if not so expressed and such charge, rate or fee is subject to change, the subscriber's contract shall require that not less than thirty (30) days' written notice of the new charge, rate or fee shall be given to the subscriber and/or his remitting agent before the change is effective;

(d) The date when the respective services and benefits become available to the subscriber, date of expiration of the contract, and the terms, if any, under which the contract may be continued or renewed;

(e) All other terms and conditions of the agreement between the parties consistent with the provisions of this chapter; and

(f) That the subscriber's contract and riders and indorsements thereon or thereto, together with application therefor, if any, signed by the subscriber, and identification issued to the subscriber, shall constitute the entire contract between the parties.

(3) No such contract shall restrict the subscriber's right to free choice of hospital or licensee, within the category or categories provided for in the contract. Such contract may provide lesser benefits for services rendered by nonparticipant licensees and/or nonparticipant hospitals than those provided by participant licensees and/or participant hospitals. Provided however,

such contract shall permit a subscriber to direct that the payment of dental care benefits to which the subscriber is entitled, pursuant to the contract, be made in the name of the nonparticipant licensee providing covered dental care services authorized by the subscriber's contract.

(4) All exceptions and exclusions in the contract shall be printed and otherwise set forth as prominently as the services or benefits to which they apply.

(5) No provision in this code shall be construed to prohibit a service corporation from issuing contracts to groups of persons under a master contract. In this event, however, each subscriber covered under the master contract shall be issued an individual certificate which shall set forth in adequate detail the provisions itemized in subsection (2) above.

(6) All proposed forms of subscriber's contracts shall be filed with the director and be subject to his approval, as provided in [section 41-3419, Idaho Code](#).

History.

1961, ch. 330, § 775, p. 645; am. 1967, ch. 399, § 9, p. 1194; am. 1971, ch. 252, § 11, p. 1008; am. 1992, ch. 185, § 1, p. 576.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 2 of S.L. 1992, ch. 185 read: "The provisions of this act shall be applicable to all subscriber contracts issued, amended, delivered, or renewed in this state on and after July 1, 1992."

CASE NOTES

[Contents of coverage booklet.](#)

[Exclusions in policy.](#)

[Contents of Coverage Booklet.](#)

An insured must be entitled to rely upon the coverage booklet with which he is furnished; accordingly, the insurer cannot be in compliance with the statutory requirements of § 41-2203 and this section and at the same time render that compliance nugatory by inserting a disclaimer which has the effect of settling a controversy as to coverage in its favor by declaring contrary policy provisions paramount over the statements of coverage set forth in the issued booklet. *Linn v. North Idaho Dist. Medical Serv. Bureau, Inc.*, 102 Idaho 679, 638 P.2d 876 (1981).

Exclusions in Policy.

It is clear from subsection (4) of this section that exceptions and exclusions are contemplated by the law and a provision in hospital and medical service insurance certificates excluding coverage of injuries resulting from torts for which a third person makes settlement or is responsible was not void as against public policy and, where insured actually recovered from tortfeasor, barred recovery on the certificate. *Smith v. Idaho Hosp. Serv., Inc.*, 89 Idaho 499, 406 P.2d 696 (1965).

Although the better practice for assurance of clarity might be to place “other insurance” clauses of a policy under a heading of “exclusions” or “limitations on coverage” or some similar term, nevertheless such provisions as contained in a policy were held to meet the demands of this section. *Medical-Dental Service, Inc. v. Boroo*, 92 Idaho 328, 442 P.2d 738 (1968).

Cited *Howard v. Blue Cross of Idaho Health Serv., Inc.*, 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

§ 41-3418. Service agreements and subscriber's contracts must provide substantial service benefits. — (1) Service agreements and subscriber's contracts entered into or issued by a service corporation on a service basis shall provide for health care services of a substantial and broad character to be rendered to subscribers on a service basis by participant licensees or participant hospitals, as the case may be and, as to participant licensees, within the scope of health care services which may otherwise lawfully be provided by the respective categories of participant licensees under the laws of Idaho.

(2) The director may, after a hearing thereon, by rules and regulations establish certain reasonable minimums of service benefits to be so provided consistent with subsection (1) above.

(3) If any group for whom a master contract is to be issued desires to enter into such contract providing either greater or lesser benefits either by way of indemnity or service to the members of such group than the issuing service corporation usually issues to similar groups, the service corporation may enter into such contract, providing, however, (a) that the request of such deviation from usual benefits and/or rates be in writing signed by the proper person representing such group setting forth the benefits desired and (b) that the master contract shall, as clearly as possible, describe in detail the benefits and rates charged, and (c) that the provisions of **section 41-3417(5), Idaho Code**, shall apply to such transaction. Should such group desire benefits less than those that may have been established under subsection (2) of this section a true copy of the executed request therefor and the master contract issued shall be filed with the director.

History.

1961, ch. 330, § 776, p. 645; am. 1967, ch. 399, § 10, p. 1194; am. 1971, ch. 252, § 12, p. 1008.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3419. Filing and approval of agreements and contracts. — (1) No service corporation shall issue or use any basic form of service agreement or subscriber's contract, or application, identification, supplement, or endorsement to be connected with any such agreement or contract, until such form has been filed with the director and approved by him. This provision shall not apply to agreements, contracts, applications, identification, supplements, endorsements or other forms of unique character designed for and used with relation to a particular set of circumstances.

(2) The director shall approve any such form unless disapproved by him on one or more of the grounds set forth in subsection (3) below. If not so approved or disapproved by order transmitted to the filing service corporation within sixty (60) days after the date filed, the form shall be deemed to have been approved, provided, however, that the director may extend by not more than an additional sixty (60) days the period within which he may so affirmatively approve or disapprove any such form, by giving notice to the service corporation of such extension before expiration of the initial sixty (60) day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved. The director may at any time, after notice and for cause shown, withdraw any such approval.

(3) The director shall disapprove any proposed form referred to in subsection (1) above which: (a) Is in any respect not in compliance with or in violation of law; or (b) Contains any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the services or benefits purported to be provided for in the general terms of the agreement or contract; or (c) Has any indication of its provisions which is misleading; or (d) Is printed or otherwise reproduced in such manner as to render any provision of the form substantially illegible.

(4) In any order of disapproval the director shall state the particulars of the grounds for disapproval.

History.

1961, ch. 330, § 777, p. 645; am. 1989, ch. 141, § 1, p. 330.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3420. Charges and rates. — (1) Subscription rates, fees, and payments to be charged by a service corporation to or on account of its subscribers shall not be excessive, inadequate, or unfairly discriminatory; and rates of payments to be made to participant physicians, participant hospitals, and participant pharmacists for services rendered under a subscriber's contract, shall be fair and reasonable.

(2) The service corporation shall, before use, file with the director a schedule of subscription rates, fees, or payments of any kind to be charged subscribers; and shall likewise so file before use every proposed change or modification in such rates, fees, or payments.

(3) If the subscriber's contracts to be issued by the service corporation provide for indemnity benefits, where permitted under this chapter, the service corporation shall include in the rate, fee, or payment required of the subscriber an adequate additional charge for such indemnity benefit, and shall separately set forth the amount of such additional charge in the schedule filed with the director.

History.

1961, ch. 330, § 778, p. 645; am. 1967, ch. 399, § 11, p. 1194.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3421. Reserves. — (1) In addition to the surplus fund provided for in section 41-3422[, Idaho Code], every service corporation shall establish and maintain unimpaired reserves as follows:

(a) Due obligations. A reserve in an amount not less than all legal obligations of the corporation, other than claims originating under subscriber's contracts, due but unpaid;

(b) Incurred losses. A reserve equal to not less than the amount necessary by reasonable estimate to pay all claims incurred under subscriber's contracts but currently unpaid, and including a reasonable additional amount to cover claims incurred but not reported to the corporation at the time of determination of the corporation's financial condition; but subject, as to amounts payable to participant physicians, participant hospitals, or participant pharmacists, to the right of the service corporation to prorate such amounts in accordance with the provisions of the service agreement;

(c) Unearned indemnity charges. A reserve equal to fifty percent of all sums charged and received by the corporation during the calendar period covered by the financial statement, on account of indemnity benefits provided in subscriber's contracts for terms for which premium was last paid and unexpired at the date of the financial statement; and

(d) Deferred service benefits. A reserve in an amount reasonably adequate to offset the additional cost thereafter to be incurred on account of deferred maternity benefits and similar deferred service benefits, such reserve to be set aside out of charges currently received on account of subscriber's contracts providing for such deferred benefits.

(2) The reserves required under subsection (1) above, shall constitute a liability of the corporation in any determination of its financial condition.

History.

1961, ch. 330, § 779, p. 645; am. 1967, ch. 399, § 12, p. 1194.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in the introductory paragraph in subsection (1) was added by the compiler to conform to the statutory citation style.

§ 41-3422. Surplus fund. — (1) Every service corporation shall set aside into a “surplus fund” an amount of money equal to not less than two per cent (2%) of all sums hereafter received by it on account of subscriber’s contracts, until such surplus fund amounts to not less than fifty thousand dollars (\$50,000) if a professional service corporation or hospital service corporation or one hundred thousand dollars (\$100,000) if a combination professional-hospital service corporation.

(2) After such minimum surplus fund is established the service corporation may in like manner increase it to an amount not to exceed the total gross collections from subscribers during the seven (7) months next preceding.

(3) That portion of the surplus fund referred to in subsection (1) above, may be used by the service corporation, by express appropriation therefrom by action of its board of directors, solely if necessary to pay the additional health care costs and expenses under its contracts, resulting from disease, epidemic or catastrophic occurrences in which numerous persons were injured in the same such occurrence.

(4) If at any time depleted below the minimum amount required under subsection (1) above, the service corporation shall replenish the fund by a resumption or continuance of allocations thereto from subscribers’ payments, as provided for original accumulation of the fund under subsection (1), or by such other reasonable means as may be approved by the director.

History.

1961, ch. 330, § 780, p. 645; am. 1967, ch. 399, § 13, p. 1194; am. 1971, ch. 252, § 13, p. 1008.

STATUTORY NOTES

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3423. Investments. — (1) A service corporation shall invest and have invested its funds in the following investments only:

- (a) Cash on deposit or in savings accounts in banks or trust companies;
- (b) Deposits in or shares of such savings and loan associations as are insured by an instrumentality of the United States government, and not in excess of the amount of such insurance in any one (1) such institution; and
- (c) Real estate for use as a home office and/or one or more branch offices, at a cost not exceeding ten per cent (10%) of the corporation's assets at the time of investment, unless a larger amount has been approved by the director.

(2) The investable funds of a service corporation may also be invested in securities and other investments permitted by and pursuant to the provisions of chapter 7, title 41, Idaho Code, and for the purposes of chapter 7, title 41, Idaho Code, a service corporation shall be deemed to be an “insurer.”

History.

1961, ch. 330, § 781, p. 645; am. 1980, ch. 215, § 1, p. 487; am. 1984, ch. 98, § 1, p. 226; am. 1997, ch. 369, § 1, p. 1175.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Cited *Howard v. Blue Cross of Idaho Health Serv., Inc.*, 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

§ 41-3424. Records and accounts. — (1) Every service corporation shall establish and maintain complete and accurate records and accounts covering its transactions and affairs, in accordance with common and accepted principles and practices of insurance accounting and recordkeeping as applied to the business of the corporation.

(2) Among other records, the corporation shall establish a separate record of each claim received for benefits under a subscriber's contract, whether such claim is for service or for indemnity. Such claim record shall contain such information as is reasonably necessary for determination of: (a) The identity of the claimant; (b) The nature of the claim; (c) The probable amount to be paid by the corporation on account of the claim; (d) Amounts actually paid by the corporation on account of the claim.

History.

1961, ch. 330, § 782, p. 645.

§ 41-3425. Annual statement. — (1) Each service corporation shall annually on or before the first day of March file with the director a statement of its financial condition as at the December 31 next preceding. The statement shall be in form, and provide for such information relative to the corporation's affairs, as the director shall prescribe consistent with this chapter. The statement shall be verified under oath by at least two (2) of the corporation's principal administrative officers.

(2) At time of filing the statement, the corporation shall pay the fee therefor as specified in section 41-3433 (fee schedule).

History.

1961, ch. 330, § 783, p. 645.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words in parentheses so appeared in the law as enacted.

§ 41-3426. Examination. — Every service corporation shall be subject to examination by the director, with the same rights and powers and in the same manner as is provided in this code for the examination of insurers; and for the purposes thereof the following sections of this code shall, to the extent so applicable, apply as to such a corporation, which, for the purpose of such application shall be deemed to be an “insurer”:

(1) Section 41-219[, Idaho Code] (examination of insurers); (2) Section 41-220[, Idaho Code] (examination of agents, managers, adjusters, promoters); (3) Section 41-221[, Idaho Code] (place of examination); (4) Section 41-223[, Idaho Code] (conduct of examination — access to records — correction of accounts — removal of records); (5) Section 41-224[, Idaho Code] (examination — appraisal of assets); (6) Section 41-225[, Idaho Code] (obstruction of examination — penalty); (7) Section 41-226[, Idaho Code] (examiners — qualifications); (8) Section 41-227[, Idaho Code] (examination report); (9) Section 41-228[, Idaho Code] (examination expense); (10) Section 41-229[, Idaho Code] (witnesses and evidence); and (11) Section 41-230[, Idaho Code] (testimony compelled — immunity from prosecution).

History.

1961, ch. 330, § 784, p. 645.

STATUTORY NOTES

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The bracketed insertions in each of the subsections were added by the compiler to conform to the statutory citation style.

The words in parentheses so appeared in the law as enacted.

CASE NOTES

Cited Howard v. Blue Cross of Idaho Health Serv., Inc., 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

§ 41-3427. Taxation and annual report. — (1) Each service corporation shall annually on or before the first day of March, file with the director a report in addition to the statement required under [section 41-3425, Idaho Code](#), (on forms as approved by the director) under oath, showing the number of subscribers' contracts, as defined under [section 41-3403\(6\), Idaho Code](#), in effect during the preceding year. A tax is hereby imposed upon each such subscriber's contract, at the rate of four cents (\$.04) per subscriber's contract, per month, such amount to be computed each month. The tax imposed hereby shall be due and payable by each service corporation to the director annually on or before the first day of March of the succeeding year.

The tax imposed hereby shall be in lieu of and in place of the premium tax provided in [section 41-402, Idaho Code](#), and except as to the tax imposed hereby, and as to the fees provided for in [section 41-3433, Idaho Code](#), the subscription income, funds and assets of every service corporation are exempt from all state, county and municipal taxes, other than payroll taxes and taxes on real estate and office furniture and equipment.

The director shall transmit and account for all taxes received by him hereunder as provided in [section 41-3433, Idaho Code](#).

(2) Any service corporation failing to render the annual statement or pay the fee required by [section 41-3425, Idaho Code](#), or to render the report or pay the tax required under subsection (1) of this section on or before the date due or within any extension of time thereof, not to exceed thirty (30) days, which the director for good cause may have granted, shall be liable to a fine of twenty-five dollars (\$25.00) for each additional day of delinquency; and the taxes shall be collected by distraint and recovered by an action to be instituted by the attorney general in the name of the state in any court of competent jurisdiction. The director shall suspend or revoke the certificate of authority of the delinquent service corporation until the statement is filed and the taxes and fine, if any, are fully paid.

History.

1961, ch. 330, § 785, p. 645; am. 1973, ch. 283, § 1, p. 599; am. 1978, ch. 9, § 1, p. 16; am. 1982, ch. 252, § 1, p. 643.

STATUTORY NOTES

Compiler's Notes.

The words in parentheses so appeared in the law as enacted.

Effective Dates.

Section 2 of S.L. 1973, ch. 283 provided the act should be in full force and effect on and after July 1, 1973.

§ 41-3428. Joint operations. — (1) A hospital service corporation and a professional service corporation may operate under joint management for the purpose of reducing operating costs.

(2) Separate records and accounts shall be kept for each such corporation, and the funds and assets of one shall not be commingled with those of the other; except that funds received from a joint billing to subscribers may be deposited in a common bank account for purposes of collection, if the records of each corporation at all times show the amount of such funds belonging to each and if final distribution of the funds is made to each corporation within thirty (30) days from receipt of payment of such joint billing.

History.

1961, ch. 330, § 786, p. 645; am. 1971, ch. 252, § 14, p. 1008.

§ 41-3429. Combined corporation. — (1) A service corporation may be formed as, or may by suitable amendment of its articles of incorporation become, a combined professional service and hospital service corporation. As to its professional services each such combined service corporation shall fully comply with those provisions of this chapter especially applicable as to professional service corporations; and as to its hospital services the corporation shall fully comply with those provisions of this chapter especially applicable as to hospital service corporations.

(2) Subject to subsection (1) above, nothing in this chapter shall be deemed to prohibit such a combined service corporation from issuing subscriber's contracts providing for both professional services and hospital services.

History.

1961, ch. 330, § 787, p. 645; am. 1971, ch. 252, § 15, p. 1008.

§ 41-3430. Contracts covering workmen's [worker's] compensation risks. — (1) No service corporation shall issue any subscriber's contract covering, or otherwise insure, any industrial injury or illness with respect to which health care service or indemnity benefits are provided by either federal or state law, or covered under the provisions of the Idaho workmen's [worker's] compensation act.

(2) The restriction set forth in subsection (1) above, shall not be construed as prohibiting hospitals or licensees, either as individuals, partnerships, or as a separate corporation, from contracting directly with employers, in their own right, with respect to such health care services as are provided for in the Idaho workmen's [worker's] compensation act.

(3) A service corporation may act as agent for such hospitals or licensees as may so contract, as referred to in subsection (2) above, for the purpose and to the extent only of the collection of moneys from the employers, the payment of claims therefrom to the hospitals or licensees, the keeping of such records as may be necessarily related thereto, and the rendering of reports to the hospitals or licensees and the Idaho industrial commission. The service corporation shall charge and receive payment of reasonable compensation for such services.

(4) The service corporation acting as agent as provided in subsection (3) above, shall not at any time be liable as to any claim arising against any employer, except to disburse on behalf of the contracting hospitals or licensees responsible as to such liability, such sums, out of the funds available, as may be awarded or payable under the workmen's [worker's] compensation act. The service corporation shall keep all such funds in separate accounts in the names of the respective hospitals or licensees, and shall not commingle them with the funds of the service corporation.

History.

1961, ch. 330, § 788, p. 645; am. 1971, ch. 252, § 16, p. 1008.

STATUTORY NOTES

Cross References.

Industrial commission, § 72-501 et seq, Worker's compensation law, § 72-101 et seq.

Compiler's Notes.

The bracketed insertions in the section heading and in subsections (1), (2), and (4) were added by the compiler to reflect the correct language in Title 72.

The name "industrial accident board" has been changed to "industrial commission" on authority of S.L. 1971, ch. 124, § 3 (§ 72-502).

§ 41-3431. Annual adjustment of service payments — Disposition of excess funds. — (1) Annually on or before March 1 every service corporation shall make a special accounting, at which time any prorated settlements for any bills submitted by participant licensees or hospitals, for services rendered during the preceding calendar year shall be adjusted, and any deficits thereon made up on a uniform basis as to all such participants to the extent of funds available therefor.

(2) Any funds of the service corporation remaining after such annual accounting, and after adequate provision for all its liabilities and reserves, and for the surplus fund required under [section 41-3422, Idaho Code](#), may be used by the corporation, upon express authorization by its board of directors, for any of the following purposes:

- (a) To liquidate on a uniform and prorata basis any charges for services by participant licensees or participant hospitals not paid in full upon the settlement of bills in previous years;
- (b) To pay off any part or the whole of any outstanding contribution of working capital to the corporation, any such payment to be prorated on a uniform basis among all such outstanding contributions; or
- (c) To reduce the rates thereafter to be charged subscribers, or to expand the services or benefits thereafter to be provided under subscription contracts.

History.

1961, ch. 330, § 789, p. 645; am. 1967, ch. 399, § 14, p. 1194; am. 1971, ch. 252, § 17, p. 1008.

§ 41-3432. Fidelity bond. — Every service corporation shall procure and maintain in force a fidelity bond or bonds, with authorized corporate surety, covering every officer or employee entrusted with the handling of its funds, in such amount, but not less than five thousand dollars (\$5,000), as may be fixed by its board of directors.

History.

1961, ch. 330, § 790, p. 645.

§ 41-3433. Service corporation fees. — (1) Every service corporation shall pay to the director fees in advance as provided for by regulation.

(2) The director shall transmit and account for all fees received by him hereunder, as provided in [section 41-406, Idaho Code](#)[.]

History.

[I.C., § 41-3433](#), as added by 1984, ch. 23, § 7, p. 38.

STATUTORY NOTES

Prior Laws.

Former § 41-3433, which comprised 1961, ch. 330, § 791, p. 645; am. 1979, ch. 122, § 6, p. 375, was repealed by S.L. 1984, ch. 23, § 1.

Compiler's Notes.

The bracketed insertion at the end of subsection (2) was added by the compiler to supply punctuation missing from the original enactment.

§ 41-3434. Other provisions applicable. — In addition to those contained or referred to heretofore in this chapter, the following chapters and provisions of title 41, Idaho Code, shall also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of such express provisions and, for the purposes of such application, such corporations shall be deemed to be mutual “insurers”:

- (1) Chapter 1, Idaho Code (scope of insurance code);
- (2) Chapter 2, Idaho Code (the department of insurance);
- (3) Section 41-308(2), Idaho Code (general eligibility for certificate of authority — competence, affiliations of management);
- (4) Sections 41-345 through 41-347, Idaho Code (disclosure of material transactions);
- (5) Section 41-601, Idaho Code (“assets” defined);
- (6) Section 41-603, Idaho Code (assets not allowed);
- (7) Section 41-604, Idaho Code (disallowance of “wash” transactions);
- (8) Section 41-613, Idaho Code (valuation of bonds);
- (9) Section 41-731, Idaho Code (prohibited investments and investment underwriting);
- (10) Chapter 13, Idaho Code (trade practices and frauds);
- (11) Section 41-2840, Idaho Code (vouchers for expenditures);
- (12) Section 41-2841, Idaho Code (borrowed surplus);
- (13) Sections 41-2857, Idaho Code (mergers and consolidations of mutual insurers), 41-2858, Idaho Code (bulk reinsurance, mutual insurers), and 41-2859, Idaho Code (mutual member’s share of assets on liquidation);
- (14) Chapter 33, Idaho Code (supervision, rehabilitation and liquidation);
- (15) Sections 799 through 809, chapter 330, laws of 1961 (transitory provisions);

(16) [Section 41-2106\(3\), Idaho Code](#) (health history application for disability insurance);

(17) [Section 41-2141, Idaho Code](#) (coordination of benefits — coordination with social security benefits);

(18) [Section 41-1839, Idaho Code](#) (attorney's fees);

(19) [Chapter 46, Idaho Code](#) (long-term care insurance act);

(20) [Section 41-1844, Idaho Code](#) (prescription drug benefit restrictions prohibited);

(21) [Section 41-2216, Idaho Code](#) (coordination of benefits — coordination with social security benefits);

(22) [Chapter 54, Idaho Code](#) (risk-based capital);

(23) [Chapter 64, Idaho Code](#) (corporate governance); and

(24) [Chapter 63, Idaho Code](#) (own risk and solvency assessment).

History.

1961, ch. 330, § 792, p. 645; am. 1976, ch. 135, § 2, p. 507; am. 1978, ch. 10, § 4, p. 19; am. 1988, ch. 8, § 1, p. 10; am. 1990, ch. 285, § 4, p. 792; am. 1991, ch. 123, § 2, p. 268; am. 1994, ch. 404, § 3, p. 1268; am. 1995, ch. 68, § 4, p. 173; am. 1997, ch. 319, § 3, p. 942; am. 2003, ch. 304, § 13, p. 833; am. 2014, ch. 319, § 8, p. 785; am. 2017, ch. 75, § 2, p. 188; am. 2017, ch. 77, § 2, p. 209; am. 2018, ch. 169, § 11, p. 344.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, added subsection (22).

This section was amended by two 2017 acts which appear to be compatible and have been compiled together.

The 2017 amendment, by ch. 75, added subsection [(24)](23) and made related changes.

The 2017 amendment, by ch. 77, added subsection (23).

The 2018 amendment, by ch. 169, inserted “Idaho Code” following section references throughout the section; substituted “scope of insurance code” for “scope of code” in subsection (1); substituted “department of insurance” for “director of insurance” in subsection (2); updated references in subsection (15); substituted “insurance act” for “insurance” in subsection (19); and redesignated one of the subsections (23) added in 2017 as subsection (24).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Except for Section 804, codified as § 41-118, and Section 805, codified as § 41-119, Sections 799 to 809 of chapter 330 of the session laws of 1961, referred to in subsection (15), were not codified, but are set out below.

Sections 799 to 803 and 806 to 809 of ch. 330, S.L. 1961, read: “**Section 799. Existing certificates of authority, continuation.** — Every certificate of authority of an insurer in force immediately prior to the effective date of this code and existing under any law herein repealed shall be valid until midnight of the March 31 next following such effective date, unless earlier terminated in accordance with this code. Such certificate of authority upon first renewal under this code shall be replaced by a certificate of authority in form as consistent with this code, and shall thereafter be subject to continuance, suspension, revocation, or termination as though originally issued under this code.

“**Section 800. Existing licenses, continuation.** Every license of an agent, broker, or adjuster in force immediately prior to the effective date of this code and existing under any law herein repealed shall be valid until midnight of the March 31 next following such effective date, unless earlier suspended, revoked, or terminated in accordance with this code. The respective such licenses upon first renewal under this code shall be replaced by a license in form consistent with this code, and shall thereafter be subject to continuation, suspension, revocation, or termination as though originally issued under this code.

“**Section 801. Existing forms and filings.** Every form of insurance document and every rate or other filing lawfully in use immediately prior to

the effective date of this code may continue to be so used or be effective until the Commissioner otherwise prescribes pursuant to this code; except, that before expiration of one (1) year from and after such effective date neither this code nor the Commissioner shall prohibit the use of any such document, rate, or filing because of any power, prohibition, or requirement contained in this code which did not exist under laws in force immediately prior to such effective date.

“Section 802. Department, commissioner’s tenure preserved. Continuation by this code of the Department of Insurance and the office of Commissioner of Insurance, existing under any law repealed herein, preserves such department and the tenure of the individual holding such office at the effective date of this code.

“Section 803. Continuation of deposits. Any deposit made in this state under any law repealed herein, with or through the Department of Insurance or the Commissioner or the State Treasurer, by any insurer in compliance with a condition precedent to or in connection with its certificate of authority to transact insurance in this state, and so on deposit immediately prior to the effective date of this code, shall be given full recognition as fulfillment, to the extent of such deposit, of any deposit so required for similar purposes under this code. The deposit shall hereafter be held for the purpose applicable thereto as specified in this code, and shall be subject in all respects to the provisions of this code applicable to similar deposits newly made under this code.

“Section 806. Saving clause. This act shall not impair or affect any act done, offense committed or right accruing, accrued or acquired or liability, penalty, forfeiture or punishment incurred prior to the time this act takes effect, but the same may be enjoyed, asserted, enforced, prosecuted or inflicted, as fully and to the same extent as if this act had not been passed.

“Section 807. Constitutionality and separability. If any section, subsection, subdivision, paragraph, sentence, part or provision of this act shall be found to be invalid or ineffective by any court it shall be conclusively presumed that this act would have been passed by the legislature without such invalid section, subsection, subdivision, paragraph, sentence, part or provision, and this act as a whole shall not be declared invalid by reason of the fact that one or more sections, subsections,

subdivisions, paragraphs, sentences, parts or provisions may be so found invalid.

“Section 808. Effective date. Except as otherwise expressly provided the respective provisions of this act, and this code, shall be in full force and effect on and after January 1, 1962.

“Section 809. Repeals. (1) Chapters 1 through 14, inclusive, chapters 16 through 30, inclusive, and chapters 32 through 40, inclusive, all of Title 41 Idaho Code, shall be and the same are hereby repealed.”

The word enclosed in parentheses so appeared in the law as enacted.

Section 4 of S.L. 2017, ch. 75 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

Section 4 of S.L. 2017, ch. 77 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

Effective Dates.

Section 6 of S.L. 1990, ch 285 declared an emergency. Approved April 5, 1990.

Section 4 of S.L. 1994, ch. 404 provided that this act shall be in full force and effect on and after January 1, 1995.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-3435. Producer licensing. — (1) Producers or persons representing a service corporation in the solicitation and negotiation of subscriber's contracts shall qualify for and be licensed as producers of the service corporation in the same manner and in compliance with the same applicable qualifications, licensing procedures and fees as apply under this code as to producers of disability insurers except that:

(a) Any such person who holds a valid license as a producer for a disability insurer issued under chapter 10, title 41, Idaho Code, may be appointed as the agent for such service corporation without further examination or other compliance with chapter 10, title 41, Idaho Code; and

(b) Nothing in this section shall prevent such person from being licensed as a producer and appointed as an agent for a life insurer or insurers under chapter 10, title 41, Idaho Code, and concurrently being licensed as a producer for such a service corporation.

(2) Service corporations may file appointment of agents or representatives in the same manner as provided in [section 41-1018, Idaho Code](#), with respect to producers of insurers.

(3) The exceptions to license requirements set forth in chapter 10, title 41, Idaho Code, shall also apply as to service corporations.

History.

[I.C., § 41-3435](#), as added by 1969, ch. 214, § 71, p. 625; am. 1977, ch. 142, § 14, p. 303; am. 2001, ch. 296, § 7, p. 1044.

§ 41-3436. Dependent's coverage — Dependent's termination of coverage, disability and dependency proof and application. — (1) Any new or renewing subscriber contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half ($\frac{1}{2}$) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

(2) There shall be a provision that a subscriber's contract delivered or issued for delivery in this state more than one hundred twenty (120) days after the effective date of this act under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child who is incapable of self-sustaining employment by reason of intellectual disability or physical disability and who became so incapable prior to attainment of the limiting age and who is chiefly dependent upon such member for support and maintenance, not to terminate while the contract remains in force and the dependent remains in such condition, if the member has within thirty-one (31) days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The service corporation may require at reasonable intervals during the two (2) years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After the two (2) year period, such subsequent proof may not be required more than once each year.

History.

I.C., § 41-3436, as added by 1972, ch. 348, § 4, p. 1030; am. 2008, ch. 296, § 3, p. 828; am. 2009, ch. 125, § 4, p. 391; am. 2010, ch. 235, § 34, p. 542.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 296, in the section catchline, added “Dependent’s coverage”; added subsection (1); and added the subsection (2) designation to the existing provisions of the section.

The 2009 amendment, by ch. 125, rewrote the first sentence in subsection (1), which formerly read: “Any subscriber contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-one (21) years or an unmarried child who is a full-time student under the age of twenty-five (25) years and who is financially dependent upon the parent shall be permitted to remain on the parent’s or parents’ contract.”

The 2010 amendment, by ch. 235, substituted “employment by reason of intellectual disability or physical disability” for “employment by reason of mental retardation or physical handicap” in the first sentence in subsection (2).

Compiler’s Notes.

The phrase “the effective date of this act” in subsection (2) refers to the effective date of S.L. 1972, Chapter 348, which was effective July 1, 1972.

Effective Dates.

Section 5 of S.L. 1972, ch. 348 provided the act should take effect from and after July 1, 1972.

§ 41-3437. Required provisions — Infants. — (a) A subscriber's contract, delivered or issued for delivery in this state which provides coverage for injury or sickness for newborn dependent children of subscribers or other members of the covered group, shall provide coverage for such newborn children, including adopted newborn children that are placed with the adoptive subscriber or other member of the covered group within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive subscriber or other member of the covered group more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive subscriber or other member of the covered group, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive subscriber or other member of the covered group signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection as to a child placed for adoption with a subscriber or other member of the covered group continues in the same manner as it would with respect to a naturally born child of the subscriber or other member of the covered group until the first to occur of the following events:

- (1) Date the child is removed permanently from that placement and the legal obligation terminates; or
- (2) The date the subscriber or other member of the covered group rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(b) A service corporation shall not restrict coverage under a subscriber's contract of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

History.

I.C., § 41-3437, as added by 1974, ch. 66, § 4, p. 1146; am. 1993, ch. 305, § 3, p. 1129; am. 1994, ch. 365, § 6, p. 1144.

STATUTORY NOTES

Effective Dates.

Section 5 of S.L. 1974, ch. 66 provided the act should take effect on and after July 1, 1974.

CASE NOTES

Newborn Enrollment Requirement.

A service company's provision in a group health policy that newborns were covered from birth only if enrolled within 30 days of birth was not per se against public policy and did not violate this section. *Howard v. Blue Cross of Idaho Health Serv., Inc.*, 114 Idaho 485, 757 P.2d 1204 (Ct. App. 1987).

§ 41-3438. Complications of pregnancy. — No hospital or medical service corporation contract which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the contract. If a fixed amount is specified in such contract for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the contract. Where the contract contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the contract. This section shall apply to all hospital or medical service corporation contracts except any group hospital or medical service corporation contract made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All contracts subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such contract which is in conflict with this section shall be of no force or effect.

History.

I.C., § 41-3438, as added by 1976, ch. 113, § 3, p. 443.

STATUTORY NOTES

Effective Dates.

Section 6 of S.L. 1976, ch. 113 provided that the act should take effect on and after January 1, 1977.

§ 41-3439. Limitation of benefits for elective abortions. — All individual nongroup or subscriber's policies, contracts, plans or certificates delivered, issued for delivery or renewed in this state after the effective date of this section shall exclude coverage for elective abortions except. Such exclusion may be waived by endorsement and the payment of a premium therefor. Availability of such coverage shall be at the option of the service corporation. For purposes of this section, an "elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

History.

I.C., § 41-3439, as added by 1983, ch. 94, § 3, p. 206.

STATUTORY NOTES

Compiler's Notes.

The phrase "effective date of this section" in the first sentence refers to the effective date of S.L. 1983, Chapter 94, which was effective July 1, 1983.

§ 41-3440. Services provided by governmental entities. — (1) From and after July 1, 1990, no hospital or professional service corporation subscriber's contract shall be issued in Idaho which excludes from coverage services rendered the subscriber while a resident in an Idaho state institution, provided the services to the subscriber would be covered by the contract if rendered to him outside an Idaho state institution.

(2) From and after July 1, 1990, no hospital or professional service corporation subscriber's contract may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a contract which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of coverage under a hospital or professional service corporation subscriber contract.

History.

I.C., § 41-3440, as added by 1990, ch. 300, § 3, p. 827.

§ 41-3441. Mammography coverage. — (1) From and after July 1, 1992, all group subscriber's contracts which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:

- (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
- (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
- (c) A mammogram every year for any woman who is fifty (50) years of age or older.
- (d) A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

History.

I.C., § 41-3441, as added by 1992, ch. 132, § 3, p. 413; am. 1993, ch. 113, § 3, p. 288.

STATUTORY NOTES

Effective Dates.

Section 6 of S.L. 1993, ch. 113 provided that the act shall be in full force and effect on July 1, 1993.

**§ 41-3442. Health insurance coverage for dependent children.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-3442, as added by 1994, ch. 365, § 7, p. 1144; am. 1998, ch. 292, § 24, p. 928, was repealed by S.L. 2003, ch. 304, § 1, effective July 1, 2003.

§ 41-3443. Best price — Most favored nations clause prohibited. —
No service corporation may require, as an element of any service agreement, that any licensee or hospital agree:

(1) To the unnegotiated adjustment by the service corporation of the licensee's or hospital's contractual reimbursement rate to equal the lowest reimbursement rate the licensee or hospital has agreed to charge any other payor;

(2) To a requirement that the licensee or hospital adjust, or enter into negotiations to adjust, their charges to the service corporation if the licensee or hospital agrees to charge another payor lower rates; or

(3) To a requirement that the licensee or hospital disclose his, her or its contractual reimbursement rates from other payors.

History.

I.C., § 41-3443, as added by 1998, ch. 422, § 3, p. 1332.

§ 41-3444. Contracts with providers of dental services. — (1) No person contracting with dentists to provide coverage or reimbursement for dental services may require, as an element of any dental care provider participation contract, that the provider agree to adopt fees set by the person for dental care services that are not covered services under the contract. “Covered services” as used in this section means dental care services and procedures under the applicable dental plan, dental plan contract, or plan benefits for which payment is available to the covered person or dentist under the covered person’s plan or contract or for which payment to the covered person or to the dentist would be available but for the application of contractual limitations on reimbursement, such as deductibles, copayments, coinsurance, and waiting periods. All services or procedures are no longer covered services, and the plan can no longer impose, contractually or otherwise, a fee schedule or other limitation when the following criteria have been met:

- (a) When the third-party payer is no longer liable for paying for an individual service or a procedure, in part or in whole, due to calendar-year limitations or benefit-year limitations; and
- (b) A patient has received dental services and procedures that equal an additional one hundred percent (100%) of the amount of the patient’s capped annual maximum benefit for the calendar year or benefit year.

Once a patient’s capped annual maximum benefit amount for a calendar year or benefit year has been exceeded by one hundred percent (100%), a dentist may choose to provide dental services or procedures according to a plan’s fee schedule or to provide dental services or procedures at a fee agreed upon with the patient. The dentist must confer with and provide notice to the patient regarding the patient’s change in fee status, and any agreed-upon fee shall not exceed the lowest fee available to the dentist’s uninsured patients.

(2) This section shall apply to any contract with providers for dental services that is issued after December 31, 2019. Contracts that are in existence on December 31, 2019, shall be brought into compliance on the

next anniversary date, renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest.

History.

I.C., § 41-3444, as added by 2010, ch. 126, § 2, p. 272; am. 2019, ch. 153, § 2, p. 505.

STATUTORY NOTES

Amendments.

The 2019 amendment, by ch. 153, rewrote the section to the extent that a detailed comparison is impracticable.

Chapter 35

INSURANCE OF PUBLIC PROPERTY AND RISKS

Sec.

41-3501. Division of purchasing to procure insurance. [Repealed.]

41-3502. Procurement of official bonds.

41-3503. Payment of premiums.

41-3504 — 41-3506. Liability insurance policies — Special endorsement
— Limited waiver of defense of sovereign immunity. [Repealed.]

§ 41-3501. Division of purchasing to procure insurance. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1961, ch. 330, § 793, p. 645; am. 1974, ch. 34, § 6, p. 988, was repealed by S.L. 1974, ch. 252, § 1, p. 1647.

§ 41-3502. Procurement of official bonds. — (1) Whenever any official surety bond is to be procured, placed, canceled or renewed with respect to any officer, agent or employee of the state of Idaho, or any of its departments, boards, agencies, or institutions, required by law or regulation to give surety bond and the premiums on which are payable from funds of the state, the same shall be so procured, placed, canceled or renewed by the administrator of the division of insurance management [risk management program] in the department of administration.

(2) The officer, agent, or employee required by law or regulation to give such surety bond shall make application therefor to the administrator and the administrator shall procure the same from authorized insurers, or as a surplus line under chapter 12, title 41, Idaho Code, on such basis as he may reasonably deem proper.

(3) If any such bond is thereafter to be canceled, modified, or renewed, the officer, agent, or employee involved, or the official having jurisdiction of such agent or employee, shall request the same in writing delivered to the administrator, and the administrator shall promptly attend to such cancellation, modification, or renewal.

History.

1961, ch. 330, § 794, p. 645; am. 1971, ch. 136, § 30, p. 522; am. 1974, ch. 34, § 7, p. 988; am. 1974, ch. 252, § 10, p. 1647; am. 1980, ch. 106, § 4, p. 231.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the end of subsection (1) was added by the compiler to correct the referenced agency's name. See <http://adm.idaho.gov/risk/>.

§ 41-3503. Payment of premiums. — Premiums on surety bonds referred to in [section 41-3502, Idaho Code](#), shall be paid from funds appropriated or available for the officer, department, board, agency, or institution for which the same is procured, on claims made by the administrator of the division of insurance management [risk management program] in the department of administration accompanied by the requisition of the officer or head of the department, board, agency, or institution, requiring any such insurance or bond.

History.

1961, ch. 330, § 795, p. 645; am. 1974, ch. 34, § 8, p. 988; 1974, ch. 252, § 11, p. 1647; am. 1977, ch. 142, § 11, p. 303; am. 1980, ch. 106, § 5, p. 231.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion near the middle of this section was added by the compiler to correct the referenced agency's name. See <http://adm.idaho.gov/risk/>.

Effective Dates.

Section 15 of S.L. 1974, ch. 34 provided the act take effect on and after July 1, 1974.

Section 15 of S.L. 1974, ch. 252 provided the act take effect on and after July 2, 1974.

§ 41-3504 — 41-3506. Liability insurance policies — Special endorsement — Limited waiver of defense of sovereign immunity. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

These sections, comprising S.L. 1961, ch. 330, §§ 796 to 798, p. 645, were repealed by S.L. 1971, ch. 150, § 29.

Chapter 36

INSURANCE GUARANTY ASSOCIATION

Sec.

41-3601. Short title.

41-3602. Purpose of act. [Repealed.]

41-3603. Application of act.

41-3604. Liberal construction of act. [Repealed.]

41-3605. Definitions.

41-3606. Insurance guaranty association — Insurers required to be members — Purposes.

41-3607. Board of directors — Number — Election or appointment — Reimbursement for expenses.

41-3608. Obligations and powers of association.

41-3609. Plan of operation — Approval — Adoption of interim rules by director — Contents of plan — Delegation of powers and duties — Reimbursement of delegate corporation or organization.

41-3610. Duties and powers of director — Judicial review.

41-3611. Subrogation of association to rights of claimants — Receiver, liquidator, or successor bound by association claim settlements — Periodic filing of statements of paid claims with receiver or liquidator.

41-3612. Exhaustion of other coverage.

41-3613. Prevention of insolvencies.

41-3614. Regulation by director — Annual reports to director.

41-3615. Exemption from taxes — Exception.

41-3616. Credits for assessments paid.

41-3617. No liability for actions taken pursuant to act.

41-3618. Stay of court proceedings for insolvency — Setting aside judgment against insolvent insurer.

41-3619. Protection of act not used to sell insurance.

41-3620. Termination of operation of association as to insurance covered by other plan — Dissolution of association and distribution of assets — Expiration of act.

41-3621. Cooperation of liquidator, receiver, or statutory successor of an insolvent insurer.

§ 41-3601. Short title. — This act shall be known and may be cited as the “Idaho insurance guaranty association act.”

History.

1970, ch. 152, § 1, p. 462.

STATUTORY NOTES

Compiler’s Notes.

The words “this act” refer to S.L. 1970, ch. 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

CASE NOTES

Legislative intent.

Recovery not limited.

Legislative Intent.

There is no clear legislative intent in the provisions of this act to inhibit or restrict the rights of a tortiously injured plaintiff against a tortfeasor. *Sherrard v. City of Rexburg*, 113 Idaho 815, 748 P.2d 399 (1988).

Recovery Not Limited.

When an insurer of an alleged tortfeasor municipality becomes insolvent, the provisions of the state insurance guaranty act do not limit a plaintiff’s amount of recovery against the tortfeasor municipality. *Sherrard v. City of Rexburg*, 113 Idaho 815, 748 P.2d 399 (1988).

§ 41-3602. Purpose of act. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised, S.L. 1970, ch. 152, § 2, p. 462, was repealed by S.L. 1997, ch. 109, § 1, effective July 1, 1997.

§ 41-3603. Application of act. — This act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

- (1) Life, annuity, health or disability insurance;
- (2) Residual value, mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;
- (3) Fidelity or surety bonds, or any other bonding obligations;
- (4) Credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;
- (5) Insurance of warranties or service contracts, including insurance that provides for the repair, replacement or service of goods or property, indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;
- (6) Title insurance;
- (7) Ocean marine insurance;
- (8) Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk;
- (9) Any insurance provided by or guaranteed by government including, but not limited to the state insurance fund, created pursuant to chapter 9, title 72, Idaho Code, and the Idaho petroleum clean water trust fund, created pursuant to chapter 49, title 41, Idaho Code;
- (10) Any insurance provided by or through any reciprocal insurer which exclusively insures members who are governmental entities;
- (11) Insurance written on a retroactive basis to cover known losses for which a claim has already been made and the claim is known to the insurer

at the time the insurance is bound; or

(12) Domestic reciprocal insurers with fewer than seven (7) subscribers which insure only worker's compensation risks and which only issue fully assessable policies.

History.

1970, ch. 152, § 3, p. 462; am. 1991, ch. 121, § 1, p. 263; am. 1991, ch. 252, § 2, p. 620; am. 1992, ch. 316, § 1, p. 942; am. 1993, ch. 279, § 4, p. 943; am. 1997, ch. 109, § 2, p. 255.

STATUTORY NOTES

Legislative Intent.

Section 1 of S.L. 1991, ch. 252 reads: "The legislature finds that the state insurance fund, created pursuant to chapter 9, title 72, Idaho Code, was not intended to be and has not been subject to the Idaho insurance guaranty association act. The legislature also finds that the Idaho petroleum clean water trust fund, created pursuant to chapter 49, title 41, Idaho Code, the trustee of which is the manager of the state insurance fund, was not intended to be and has not been subject to the Idaho insurance guaranty association act and by this act, desires to confirm those legislative purposes."

Compiler's Notes.

The term "this act" in the introductory paragraph refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-3604. Liberal construction of act. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section which comprised, S.L. 1970, ch. 152, § 4, p. 462, was repealed by S.L. 1997, ch. 109, § 3, effective July 1, 1997.

§ 41-3605. Definitions. — As used in this act:

(1) “Account” means the account created by [section 41-3606, Idaho Code](#).

(2) “Affiliate” means a person who directly, or indirectly, through one (1) or more intermediaries controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(3) “Association” means the Idaho insurance guaranty association created under [section 41-3606, Idaho Code](#).

(4) “Claimant” means any insured making a first party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(5) “Director” means the director of the department of insurance of this state.

(6) “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

(7) “Covered claim” means an unpaid claim, including one for unearned premiums submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this act applies issued by an insurer, if such insurer becomes an insolvent insurer after the effective date of this act and:

(a) The claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the

residence of a claimant, insured, or policyholder is the state in which its principal place of business is located at the time of the insured event; or

(b) The claim is a first party claim for damage to property with a permanent location in this state.

“Covered claim” shall not include any amount awarded as punitive or exemplary damages; any amount sought as a return of premium under any retrospective rating plan; any first party claims by an insured which is an affiliate of the insolvent insurer; or any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool or underwriting association may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the association obligation limitations set forth in [section 41-3608, Idaho Code](#).

(8) “Insolvent insurer” means an insurer holding a certificate of authority issued by the director to transact insurance in this state either at the time the policy was issued or when the insured event occurred and against whom a final order of liquidation has been entered after the effective date of this act with a finding of insolvency by a court of competent jurisdiction in the insurer’s state of domicile.

(9) “Member insurer” means any person who:

(a) Writes any kind of insurance to which this act applies under [section 41-3603, Idaho Code](#), including the exchange of reciprocal or interinsurance contracts; and

(b) Is licensed to transact insurance in this state, except assessable mutual companies. An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this act applies, however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer’s license and assessments levied after the termination or expiration, which relate to any insurer which becomes an insolvent insurer prior to the termination or expiration of the insurer’s license.

(10) “Net direct written premiums” means direct gross premiums written in this state on insurance policies to which this act applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. “Net direct written premiums” does not include premiums on contracts between insurers or reinsurers.

(11) “Ocean marine insurance” includes any form of insurance, regardless of the name, label or marketing designation of the insurance policy, which insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Such perils and risks insured against include, without limitation, loss, damage, expense or legal liability of the insured for loss, damage or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness or death or for loss or damage to the property of the insured or another person.

(12) “Person” means any individual, corporation, partnership, association or voluntary organization.

(13) “Warranty insurance” includes a contract under which one (1) other than a manufacturer, builder, seller or lessor of the subject property undertakes to perform or provide, for a fixed term and consideration, repair or replacement service or indemnification therefor for the operational or structural failure of specified real or personal property or property components. Warranty insurance includes, but is not limited to, automobile guaranty insurance.

History.

1970, ch. 152, § 5, p. 462; am. 1981, ch. 54, § 1, p. 82; am. 1987, ch. 124, § 1, p. 254; am. 1991, ch. 121, § 2, p. 263; am. 1992, ch. 316, § 2, p. 942; am. 1997, ch. 109, § 4, p. 255; am. 2001, ch. 155, § 1, p. 558.

STATUTORY NOTES

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase “the effective date of this act” in the introductory paragraph in subsection (7) refers to the effective date of S.L. 1970, Chapter 152, which was effective May 6, 1970.

The phrase “the effective date of this act” in subsection (8) refers to the effective date of S.L. 1997, Chapter 109, which was effective July 1, 1997.

The term “this act” in the introductory paragraph, in the introductory paragraph in subsection (7), in paragraphs (9)(a) and (9)(b), and in subsection (10) refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

Effective Dates.

Section 3 of S.L. 1991, ch. 121 declared an emergency. Approved March 28, 1991.

CASE NOTES

Cited Maguire, Ward, Maguire & Eldredge v. Idaho Ins. Guar. Ass’n, 112 Idaho 166, 730 P.2d 1086 (Ct. App. 1986).

§ 41-3606. Insurance guaranty association — Insurers required to be members — Purposes. — There is created a nonprofit unincorporated legal entity to be known as the Idaho insurance guaranty association. All insurers defined as member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under [section 41-3609, Idaho Code](#), and shall exercise its powers through a board of directors established under [section 41-3607, Idaho Code](#). For purposes of administration and assessment, the association shall maintain one (1) account. Any accounts in existence on June 30, 2001, shall be consolidated into one (1) account.

History.

1970, ch. 152, § 6, p. 462; am. 2001, ch. 155, § 2, p. 558.

CASE NOTES

Cited [Maguire, Ward, Maguire & Eldredge v. Idaho Ins. Guar. Ass'n, 112 Idaho 166, 730 P.2d 1086 \(Ct. App. 1986\).](#)

§ 41-3607. Board of directors — Number — Election or appointment — Reimbursement for expenses. — (1) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the director. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the director. If no members are selected within sixty (60) days after May 6, 1970, the director may appoint the initial members of the board of directors.

(2) In approving selections to the board, the director shall consider among other things whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

History.

1970, ch. 152, § 7, p. 462; am. 1997, ch. 109, § 5, p. 255.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3608. Obligations and powers of association. — (1) The association shall:

(a) Be obligated to pay covered claims existing prior to the order of liquidation arising within thirty (30) days after the order of liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if he does so within thirty (30) days of the order of liquidation. Such obligation shall be satisfied by paying to the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a worker's compensation insurance coverage;

(ii) An amount not exceeding ten thousand dollars (\$10,000) per policy for covered claim for the return of unearned premium;

(iii) An amount not exceeding three hundred thousand dollars (\$300,000) per claim for all other covered claims.

(b) In no event shall the association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.

Notwithstanding any other provision of this chapter, a covered claim shall not include any claim filed with the association after the earlier of: (i) eighteen (18) months after the date of the order of liquidation, or (ii) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer and shall not include any claim filed with the association or a liquidator for protection afforded under the insured policy for incurred-but-not-reported losses. Any obligation of the association to defend an insured shall cease upon the association's payment by settlement releasing the insured or on a judgment of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit.

(c) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent including,

but not limited to, the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations.

(d) Assess member insurers separately for amounts necessary to pay the obligations of the association under paragraph (a) of this subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this chapter. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance covered by the account bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment on the kinds of insurance covered by the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any one (1) year an amount greater than one percent (1%) of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association in the account, does not provide in any one (1) year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association shall pay claims in any order which it deems reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account.

(e) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested. The association shall have the right to appoint or substitute and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

(f) Handle claims through its employees or through one (1) or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the director, but such designation may be declined by a member insurer.

(g) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this chapter.

(2) The association may:

(a) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(b) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation.

(c) Sue or be sued, and such power to sue includes the power and right to intervene as a party before any court that has jurisdiction over the insolvent insurer as defined by this chapter.

(d) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this chapter.

(e) Perform such other acts as are necessary or proper to effectuate the purpose of this chapter.

(f) Refund to the member insurers in proportion to the contribution of each member insurer that amount which, in the opinion of the board of directors, will not be needed for the purposes of this chapter within two (2) years from the date the association receives the refund from the receivership.

(g) Subject to approval by the director, provide claims handling services to any run-off insurer, provided the association expenses related to such services are fully reimbursed. Normal defenses applicable to guaranty fund handling of covered claims shall not apply to run-off claim handling and no guaranty fund assets shall be used for run-off claim or expense payment. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, the association or its agents or employees, the board of directors or any person serving as a representative of any director for any action taken or any failure to act by them in the performance of their activities under the provisions of this paragraph. For purposes of this paragraph, “run-off insurer” means a property and casualty insurer that has:

(i) Total adjusted capital under risk-based capital requirements in an amount less than the authorized control level risk-based capital as defined in section 41-5401(11)(a) [(13)(a)], Idaho Code, and has indicated that it will cease writing new insurance policies, either as part of its corrective action plan or pursuant to being placed under regulatory control; or

(ii) Total adjusted capital under risk-based capital requirements in an amount less than the mandatory control level risk-based capital as defined in section 41-5401(11)(c) [(13)(c)], Idaho Code, and that has not been placed into liquidation pursuant to sections 41-3317 and 41-3318, Idaho Code.

History.

1970, ch. 152, § 8, p. 462; am. 1980, ch. 275, § 1, p. 718; am. 1984, ch. 66, § 1, p. 115; am. 1992, ch. 316, § 3, p. 942; am. 1993, ch. 279, § 1, p. 943; am. 1997, ch. 109, § 6, p. 255; am. 2001, ch. 155, § 3, p. 558; am. 2005, ch. 268, § 1, p. 829; am. 2014, ch. 89, § 1, p. 239.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 89, added paragraph (2)(g).

Compiler’s Notes.

The bracketed insertions in paragraphs (2)(g)(i) and (2)(g)(ii) were added by the compiler to account for the amendment of § 41-5401 by S.L. 2014, ch. 319, § 1.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

CASE NOTES

Attorney Fees.

The insurance guaranty association was not required to pay attorney fees incurred by an insurance company before it became insolvent. *Maguire, Ward, Maguire & Eldredge v. Idaho Ins. Guar. Ass’n*, 112 Idaho 166, 730 P.2d 1086 (Ct. App. 1986).

§ 41-3609. Plan of operation — Approval — Adoption of interim rules by director — Contents of plan — Delegation of powers and duties — Reimbursement of delegate corporation or organization. —

(1)(a) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the director.

(b) If the association fails to submit a suitable plan of operation within ninety (90) days following May 6, 1970 or if at any time thereafter the association fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this act. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall:

(a) Establish the procedures whereby all the powers and duties of the association under [section 41-3608, Idaho Code](#), will be performed.

(b) Establish procedures for handling assets of the association.

(c) Establish procedures for the disposition of liquidating dividends or other moneys received from the estate of the insolvent insurer.

(d) Establish the amount and method of reimbursing members of the board of directors under [section 41-3607, Idaho Code](#).

(e) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(f) Establish regular places and times for meetings of the board of directors.

(g) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(h) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the director within thirty (30) days after the action or decision.

(i) Establish the procedures whereby selections for the board of directors will be submitted to the director.

(j) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under sections 41-3608(1)(d) and 41-3608(2)(b), Idaho Code, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this act.

History.

1970, ch. 152, § 9, p. 462; am. 1997, ch. 109, § 7, p. 255.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The term “this act” in paragraph (1)(b) and at the end of subsection (4) refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-

3605 to 41-3620.

§ 41-3610. Duties and powers of director — Judicial review. — (1)

The director shall:

(a) Notify the association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency. The association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that such complaint is filed with a court of competent jurisdiction.

(b) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(2) The director may:

(a) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the director may levy a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed five per cent (5%) of the unpaid assessment per month, except that no fine shall be less than one hundred dollars (\$100) per month.

(b) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

(3) Any final action or order of the director under this act shall be subject to judicial review in a court of competent jurisdiction.

History.

1970, ch. 152, § 10, p. 462; am. 1997, ch. 109, § 8, p. 255.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in subsection (3) refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3611. Subrogation of association to rights of claimants — Receiver, liquidator, or successor bound by association claim settlements — Periodic filing of statements of paid claims with receiver or liquidator. — (1) Any person recovering under this act shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this act shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(2) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of claims made by the association or a similar organization in another state to the extent such determinations or settlements satisfy obligations of the association. The receiver shall not be bound in any way by such determinations or settlements to the extent there remains a claim against the insolvent insurer. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this act against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(3) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

History.

1970, ch. 152, § 11, p. 462; am. 1997, ch. 109, § 9, p. 255.

STATUTORY NOTES

Compiler's Notes.

The term “this act” in subsections (1) and (2) refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

§ 41-3612. Exhaustion of other coverage. — (1) Any person having a claim against an insurer, whether or not the insurer is a member insurer, under any provision in an insurance policy other than a policy of an insolvent insurer which is also a covered claim, shall be required to exhaust first his right under such policy. Any amount payable on a covered claim under this act shall be reduced by the amount of any recovery under such insurance policy.

(2) Any person having a claim which may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the association of the location of the property, and if it is a worker's compensation claim, he shall seek recovery first from the association of the residence of the claimant. Any recovery under this act shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

History.

1970, ch. 152, § 12, p. 462; am. 1997, ch. 109, § 10, p. 255.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in subsections (1) and (2) refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

CASE NOTES

Cited *Sherrard v. City of Rexburg*, 113 Idaho 815, 748 P.2d 399 (1988).

§ 41-3613. Prevention of insolvencies. — To aid in the detection and prevention of insurer insolvencies:

(1) The board of directors, upon majority vote, may make recommendations to the director for the detection and prevention of insurer insolvencies. Such recommendations shall not be considered public documents.

(2) The board of directors may, upon majority vote, make recommendations on matters generally relating to improving or enhancing regulation for solvency.

(3) The board of directors may, at the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association and submit such report to the director.

(4) All domestic insurance companies subject to the coverage of this chapter must maintain the paid-up capital stock or basic surplus and the additional surplus set forth in [section 41-313, Idaho Code](#).

(5) Domestic reciprocal insurance companies issuing only fully assessable worker's compensation policies are not subject to coverage of this chapter but must meet the requirements of [section 41-313A, Idaho Code](#).

History.

1970, ch. 152, § 13, p. 462; am. 1992, ch. 316, § 4, p. 942; am. 1993, ch. 279, § 2, p. 943; am. 1997, ch. 109, § 11, p. 255.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Effective Dates.

Section 5 of S.L. 1992, ch. 316 declared an emergency. Approved April 9, 1992.

§ 41-3614. Regulation by director — Annual reports to director. —

The association shall be subject to examination and regulation by the director. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the director.

History.

1970, ch. 152, § 14, p. 462.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3615. Exemption from taxes — Exception. — The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

History.

1970, ch. 152, § 15, p. 462.

§ 41-3616. Credits for assessments paid. — (1) A member insurer may offset against its premium tax liability to this state under [section 41-402, Idaho Code](#), an assessment described in subsection (1)(d) of [section 41-3608, Idaho Code](#). An offset is allowable to the extent of twenty percent (20%) of the amount of such assessment for each of five (5) calendar years beginning with the premium tax due under [section 41-402\(4\), Idaho Code](#), with respect to the year of payment of the assessment and thereafter with the premium tax due under [section 41-402\(4\), Idaho Code](#), during each of the four (4) succeeding years. An allowable offset, or portion thereof, not used in any calendar year cannot be carried over or back to any other year. An insurer that is exempt from the premium tax imposed by [section 41-402, Idaho Code](#), may offset against its premium tax liability to the industrial administration fund in the same manner as an offset to the premium tax imposed by [section 41-402\(4\)](#).

(2) Notwithstanding any provision to the contrary in [section 41-3608\(2\)\(f\), Idaho Code](#), any sums acquired by refund from insurance company receiverships by the association which have heretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and which, in the opinion of the board of directors, will not be needed for the purposes of this chapter within two (2) years from the date the association receives the refund from the receivership, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the state general fund.

History.

1970, ch. 152, § 16, p. 462; am. 2004, ch. 241, § 1, p. 704; am. 2005, ch. 268, § 2, p. 829; am. 2013, ch. 265, § 1, p. 650.

STATUTORY NOTES

Cross References.

General fund, § 67-1205.

Industrial administration fund, §§ 72-519 to 72-527.

State treasurer, § 67-1201 et seq.

Amendments.

The 2013 amendment, by ch. 265, rewrote subsection (1) to the extent that a detailed comparison is impracticable.

Effective Dates.

Section 2 of S.L. 2004, ch. 241 declared an emergency retroactively to January 1, 2004. Approved March 23, 2004.

§ 41-3617. No liability for actions taken pursuant to act. — There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors, or any person serving as a representative of any board director, or the director or his representatives for any action taken or any failure to act by them in the performance of their powers and duties under this act.

History.

1970, ch. 152, § 17, p. 462; am. 1997, ch. 109, § 12, p. 255.

STATUTORY NOTES

Compiler's Notes.

The term “this act” at the end of the section refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3618. Stay of court proceedings for insolvency — Setting aside judgment against insolvent insurer. — All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall, subject to written waiver by the association in specific cases involving covered claims, be stayed until the last day fixed by the court for the filing of claims and such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict or findings based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of such insured may apply to have such judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and shall be permitted to defend against such claim on the merits. The liquidator, receiver, or statutory successor of an insolvent insurer covered by this act shall permit access by the board or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this act with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.

History.

1970, ch. 152, § 18, p. 462; am. 1981, ch. 54, § 2, p. 82; am. 1997, ch. 109, § 13, p. 255.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in the next-to-last sentence refers to S.L. 1997, Chapter 109, which is codified as §§ 41-3603, 41-3605, 41-3607 to 41-3613, 41-3617, and 41-3618.

§ 41-3619. Protection of act not used to sell insurance. — It is an unfair trade practice for any insurer or agent to in any manner make use of the protection given policyholders by this chapter as a reason for buying insurance from him.

History.

1970, ch. 152, § 19, p. 462.

STATUTORY NOTES

Cross References.

Unfair trade, § 41-1301 et seq.

§ 41-3620. Termination of operation of association as to insurance covered by other plan — Dissolution of association and distribution of assets — Expiration of act. — (1) The director shall by order terminate the operation of the Idaho insurance guaranty association as to any kind of insurance covered by this act with respect to which he has found, after hearing, that there is in effect a statutory or voluntary plan which:

(a) Is a permanent plan which is adequately funded or for which adequate funding is provided.

(b) Extends, or will extend to the Idaho policyholders and residents protection and benefits with respect to insolvent insurers not substantially less favorable and effective to such policyholders and residents than the protection and benefits provided with respect to such kinds of insurance under this act.

(2) The director shall by the same such order authorize discontinuance of future payments by insurers to the Idaho insurance guaranty association with respect to the same kinds of insurance; provided, the assessments and payments shall continue, as necessary, to liquidate covered claims of insurers adjudged insolvent prior to said order and the related expenses not covered by such other plan.

(3) In the event the operation of the Idaho insurance guaranty association shall be so terminated as to all kinds of insurance otherwise within its scope, the association as soon as possible thereafter shall distribute the balance of moneys and assets remaining (after discharge of the functions of the association with respect to prior insurer insolvencies not covered by such other plan, together with related expenses) to the insurers which are then writing in this state policies of the kinds of insurance covered by this act and which had made payments to the association, pro rata upon the basis of the aggregate of such payments made by the respective insurers during the period of five (5) years next preceding the date of such order. Upon completion of such distribution with respect to all of the kinds of insurance covered by this act, this act shall be deemed to have expired.

History.

1970, ch. 152, § 20, p. 462.

STATUTORY NOTES

Compiler's Notes.

The term “this act” in the introductory paragraph in subsection (1), in paragraph (1)(b) and in subsection (3) refers to S.L. 1970, Chapter 152, compiled as §§ 41-3601, 41-3603, and 41-3605 to 41-3620.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words in parentheses so appeared in the law as enacted.

§ 41-3621. Cooperation of liquidator, receiver, or statutory successor of an insolvent insurer. — The liquidator, receiver, or statutory successor of an insolvent insurer covered by this act shall permit access by the board of directors or its authorized representative to such of the insolvent insurer's records which are necessary for the board in carrying out its functions under this act with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board of directors or its authorized representative with copies of such records upon the request by the board of directors and at the expense of the board of directors.

History.

I.C., § 41-3621, as added by 1981, ch. 54, § 3, p. 82.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in the first sentence refers to S.L. 1981, Chapter 54, which is compiled as §§ 41-3605, 41-3618 and 41-3621.

Chapter 37
IDAHO HOSPITAL LIABILITY TRUST ACT

Sec.

41-3701 — 41-3729. [Repealed.]

Idaho Code § 41-3701

§ 41-3701. Declaration of purpose. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3701, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3702

§ 41-3702. Definitions. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3702, as added by 1977, ch. 204, § 2, p. 555.

**§ 41-3703. Trust agreements among a group of hospitals authorized.
[Repealed.]**

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3703, as added by 1977, ch. 204, § 2, p. 555.

§ 41-3704. Title to property of trusts — Liability of trusts and trustees. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3704, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3705

§ 41-3705. Obligation of participating hospitals limited. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3705, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3706

§ 41-3706. Registration. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3706, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3707

§ 41-3707. Qualifications for registration. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3707, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3708

§ 41-3708. Application for registration — Fee. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3708, as added by 1977, ch. 204, § 2, p. 555; am. 1984, ch. 23, § 10, p. 38.

Idaho Code § 41-3709

§ 41-3709. Grant or denial of registration. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3709, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3710

§ 41-3710. Trust fund — Powers. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3710, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3711

§ 41-3711. Trust fund — Liability.[Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3711, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3712

§ 41-3712. Investment of trust fund. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3712, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3713

§ 41-3713. Reserves. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3713, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3714

§ 41-3714. Records and accounts — Annual statement. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3714, as added by 1977, ch. 204, § 2, p. 555; am. 1984, ch. 23, § 11, p. 38.

Idaho Code § 41-3715

§ 41-3715. Taxes. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3715, as added by 1977, ch. 204, § 2, p. 555; am. 1984, ch. 253, § 2, p. 604; am. 1988, ch. 366, § 6, p. 1077.

Idaho Code § 41-3716

§ 41-3716. Examination of books, records and accounts. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3716, as added by 1977, ch. 204, § 2, p. 555; am. 2001, ch. 85, § 10, p. 211.

Idaho Code § 41-3717

§ 41-3717. Trustees — Administrators — Bonding. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3717, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3718

**§ 41-3718. Prohibited pecuniary interests in plan management.
[Repealed.]**

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3718, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3719

§ 41-3719. Political contributions prohibited. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3719, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3720

§ 41-3720. Recovery of depleted funds. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3720, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3721

§ 41-3721. Termination of registration. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3721, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3722

§ 41-3722. Liquidation of trust fund. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3722, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3723

§ 41-3723. Other provisions applicable. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3723, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3724

§ 41-3724. Penalties. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3724, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3725

§ 41-3725. Rules and regulations. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3725, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3726

§ 41-3726. Application of chapter. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3726, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3727

§ 41-3727. Insurance. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3727, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3728

§ 41-3728. Certificate of membership. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3728, as added by 1977, ch. 204, § 2, p. 555.

Idaho Code § 41-3729

§ 41-3729. Severability. [Repealed.]

Repealed by S.L. 2020, ch. 115, § 1, effective July 1, 2020.

History.

I.C., § 41-3729, as added by 1977, ch. 204, § 2, p. 555.

Chapter 38

ACQUISITIONS OF CONTROL AND INSURANCE HOLDING COMPANY SYSTEMS

Sec.

41-3801. Purpose.

41-3802. Definitions.

41-3803. Subsidiaries of insurers.

41-3804. Acquisition of control of controlling interest with domestic insurer
— Acquisition of merger or divestiture of controlling interest with
domestic insurer.

41-3805. Tender offer material.

41-3806. Approval by director — Hearings.

41-3807. Mailing — Payment of expenses.

41-3808. Acquisitions involving insurers not otherwise covered.

41-3809. Registration of holding company system insurers.

41-3810. Standards and management of an insurer within an insurance
holding company system.

41-3811. Adequacy of surplus.

41-3812. Dividends and other distributions.

41-3813. Management of domestic insurers subject to registration.

41-3814. Examination.

41-3815. Supervisory colleges.

41-3815A. Group-wide supervision of internationally active insurance
groups.

41-3816. Confidential treatment.

41-3817. Rules.

41-3818. Injunctions, prohibitions against voting securities, sequestration of voting securities.

41-3819. Sanctions.

41-3820. Receivership.

41-3821. Recovery.

41-3822. Revocation, suspension or nonrenewal of insurer's license.

41-3823. Judicial review — Mandamus.

41-3824. Mutual insurance holding companies.

41-3825. Severability.

§ 41-3801. Purpose. — The purpose of this chapter is to prevent acquisition or divestiture of control of an insurer or a holding company system of which an insurer is a part where such acquisition would be adverse to the public interest and the interests of policyholders and shareholders. A further purpose of this chapter is to promote the public interest and the interests of policyholders and shareholders by facilitating, consistent with those interests, better use of management skills and services, diversification through acquisitions, free access to capital markets, sound tax planning and open competition. An additional purpose is to monitor and regulate insurance holding company systems.

History.

I.C., § 41-3801, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former chapter 38 of Title 41, which comprised the following sections, was repealed by S.L. 2013, ch. 266, § 1, effective July 1, 2013.

41-3801. Definitions. [**I.C., § 41-3801**, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 15, p. 492.]

41-3801A. Purpose. [**I.C., § 41-3801A**, as added by 1981, ch. 214, § 1, p. 382.]

41-3801B. Subsidiaries of insurers. [**I.C., § 41-3801B**, as added by 1993, ch. 194, § 16, p. 492.]

41-3802. Acquisition of control of a domestic insurer. [**I.C., § 41-3802**, as added by 1981, ch. 214, § 3, p. 382; am. 1982, ch. 266, § 1, p. 686; am. 1990, ch. 213, § 59, p. 480; am. 1993, ch. 194, § 17, p. 492.]

41-3803. Tender offer material. [**I.C., § 41-3803**, as added by 1972, ch. 163, § 1, p. 365.]

41-3805. Approval, disapproval of proposed acquisition. [**I.C., § 41-3805**, as added by 1972, ch. 163, § 1, p. 365; am. 1981, ch. 214, § 4, p. 382;

am. 1982, ch. 266, § 2, p. 686; am. 1990, ch. 375, § 1, p. 1037; am. 1993, ch. 194, § 19, p. 492; am. 1998, ch. 303, § 3, p. 997.]

41-3805A. Mailing — Payment of expenses. [I.C., § 41-3805A, as added by 1981, ch. 214, § 5, p. 382; am. 1982, ch. 266, § 3, p. 686.]

41-3805B. Acquisitions involving insurers not otherwise covered. [I.C., § 41-3805B, as added by 1993, ch. 194, § 20, p. 492.]

41-3806. Registration of holding company system insurers. [I.C., § 41-3806, as added by 1972, ch. 163, § 1, p. 365; am. 1981, ch. 214, § 6, p. 382; am. 1993, ch. 194, § 21, p. 492; am. 1996, ch. 305, § 3, p. 1000; am. 1999, ch. 65, § 8, p. 168.]

41-3807. Transactions with affiliates — Standards. [I.C., § 41-3807, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 22, p. 492.]

41-3808. Insurers surplus — Adequacy factors. [I.C., § 41-3808, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 23, p. 492.]

41-3809. Dividends and distributions. [I.C., § 41-3809, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 24, p. 492.]

41-3810. Verification of information. [I.C., § 41-3810, as added by 1972, ch. 163, § 1, p. 365; am. 1993, ch. 194, § 25, p. 492.]

41-3811. Communications. [I.C., § 41-3811, as added by 1972, ch. 163, § 1, p. 365; am. 1990, ch. 213, § 60, p. 480.]

41-3813. Rules and regulations. [I.C., § 41-3813, as added by 1972, ch. 163, § 1, p. 365.]

41-3814. Supplemental to existing provisions. [I.C., § 41-3814, as added by 1993, ch. 194, § 28, p. 492.]

41-3815. Injunctions. [I.C., § 41-3815, as added by 1981, ch. 214, § 7, p. 382; am. 1993, ch. 194, § 29, p. 492.]

41-3816. Sanctions. [I.C., § 41-3816, as added by 1993, ch. 194, § 30, p. 492.]

41-3817. Receivership. [I.C., § 41-3817, as added by 1993, ch. 194, § 31, p. 492.]

41-3818. Recovery. [I.C., § 41-3818, as added by 1993, ch. 194, § 32, p. 492.]

41-3819. Revocation, suspension, or nonrenewal of insurer's license. [I.C., § 41-3819, as added by 1993, ch. 194, § 33, p. 492.]

41-3820. Judicial review, mandamus. [I.C., § 41-3820, as added by 1993, ch. 194, § 34, p. 492.]

41-3821. Mutual insurance holding companies. [I.C., § 41-3821, as added by 1998, ch. 303, § 1, p. 998; am. 2003, ch. 271, § 1, p. 722; am. 2004, ch. 30, § 1, p. 53; am. 2004, ch. 45, § 7, p. 169.]

Compiler's Notes.

The name "commissioner of insurance" has been changed to "director of the department of insurance" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 36 of S.L. 1993, ch. 194 read: "For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer."

Effective Dates.

Section 2 of S.L. 1972, ch. 163 provided that the act should take effect from and after October 1, 1972.

§ 41-3802. Definitions. — As used in this chapter, the following terms shall have the following meanings:

(1) “Affiliate” of, or a person “affiliated” with, a specific person, means a person who directly or indirectly through one (1) or more intermediaries controls or is controlled by, or is under common control with, the person specified.

(2) “Control,” including “controlling,” “controlled by” and “under common control with,” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or a corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in [section 41-3809\(11\), Idaho Code](#), that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) “Enterprise risk” means any activity, circumstance, event or series of events involving one (1) or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole including, but not limited to, anything that would cause the insurer’s risk-based capital to fall into company action level as set forth in [section 41-5403, Idaho Code](#), or would cause the insurer to be in hazardous financial condition as set forth by rule in [IDAPA 18.01.66](#).

(4) “Group-wide supervisor” means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the director under [section 41-](#)

3815A, Idaho Code, to have sufficient significant contacts with the internationally active insurance group.

(5) “Insurance holding company system” means two (2) or more affiliated persons, one (1) or more of whom is an insurer.

(6) “Insurer” has the same meaning as that set forth in section 41-103, Idaho Code, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision of a state.

(7) “Internationally active insurance group” means an insurance holding company system that:

(a) Includes an insurer registered under section 41-3809, Idaho Code; and

(b) Meets the following criteria:

(i) Premiums written in at least three (3) countries;

(ii) The percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system’s total gross written premiums; and

(iii) Based on a three (3) year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars (\$50,000,000,000) or the total gross written premiums of the insurance holding company system are at least ten billion dollars (\$10,000,000,000).

(8) “Person” means an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a business trust, an unincorporated organization, or any similar entity or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing or developing real or tangible personal property.

(9) “Security holder” means a person who owns any security of a specified person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

(10) “Subsidiary” means a specified person who is an affiliate controlled by such person directly or indirectly through one (1) or more intermediaries.

(11) “Voting security” means any security convertible into or evidencing a right to acquire a voting security.

History.

I.C., § 41-3802, as added by 2013, ch. 266, § 2, p. 652; am. 2019, ch. 81, § 1, p. 188.

STATUTORY NOTES

Prior Laws.

Former § 41-3802 was repealed. See Prior Laws, § 41-3801.

Another former § 41-3802, which comprised **I.C., § 41-3802**, as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1981, ch. 214, § 2, effective April 6, 1981.

Amendments.

The 2019 amendment, by ch. 81, added subsections (4) and (7) and redesignated the remaining subsections accordingly.

Compiler’s Notes.

Section 4 of S.L. 2019, ch. 81 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

§ 41-3803. Subsidiaries of insurers. — (1) A domestic insurer, either by itself or in cooperation with one (1) or more persons, may organize or acquire one (1) or more subsidiaries. The subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

(2) In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under title 41, Idaho Code, a domestic insurer may also:

(a) Invest in common stock, preferred stock, debt obligations and other securities of one (1) or more subsidiaries in amounts that do not exceed the lesser of ten percent (10%) of the insurer's assets or fifty percent (50%) of the insurer's surplus regarding policyholders, provided that after making such investments, the insurer's surplus regarding policyholders will be reasonable in relation to the insurer's outstanding liabilities and will be adequate to meet its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries shall be excluded, but the following shall be included:

(i) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and

(ii) All amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation.

(b) Invest any amount in common stock, preferred stock, debt obligations and other securities of one (1) or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, provided that each subsidiary agrees to limit its investment in any asset so that the investment will not

cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in paragraph (a) of this subsection or in chapter 7, title 41, Idaho Code, applicable to the insurer. For the purpose of this section, "the total investment of the insurer" shall include:

(i) Any direct investment by the insurer in an asset; and

(ii) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary.

(c) With the approval of the director, invest any greater amount in common stock, preferred stock, debt obligations or other securities of one (1) or more subsidiaries, provided that after making the investment, the insurer's surplus regarding policyholders will be reasonable in relation to the insurer's outstanding liabilities and will be adequate to its financial needs.

(3) Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection (2)(a) of this section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in title 41, Idaho Code, applicable to such investments of insurers.

(4) Whether any investment made pursuant to subsection (2) of this section meets the applicable requirements thereof is to be determined before the investment is made by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

(5) If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the director may prescribe, unless at any time after the investment shall have been made the investment shall have met the requirements for investment

under any other section of title 41, Idaho Code, and the insurer has so notified the director.

History.

I.C., § 41-3803, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3803 was repealed. See Prior Laws, § 41-3801.

§ 41-3804. Acquisition of control of controlling interest with domestic insurer — Acquisition of merger or divestiture of controlling interest with domestic insurer. — (1) The following filing requirements shall apply:

(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time the offer, request or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, such person has filed with the director and has sent to the insurer, a statement containing the information required by this section and the offer, request, invitation, agreement or acquisition has been approved by the director in the manner prescribed in this chapter.

(b) For purposes of this section, any controlling person of a domestic insurer seeking to divest his controlling interest of the domestic insurer, in any manner, shall file with the director, with a copy to the insurer, confidential notice of his proposed divestiture at least thirty (30) days prior to the cessation of control. The director shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the director, in his discretion, determines that confidential treatment will interfere with or impede enforcement of this section. If the statement referred to in paragraph (a) of this subsection is otherwise filed, this section shall not apply.

(c) With respect to a transaction subject to this section, the acquiring or divesting person must also file a preacquisition notification with the

director that contains the information set forth in [section 41-3808\(3\)\(a\), Idaho Code](#), at least thirty (30) days prior to the proposed effective date of the acquisition. A failure to timely file the notification may subject the acquiring or divesting person to penalties as specified in [section 41-3808\(5\)\(e\), Idaho Code](#).

(d) For purposes of this section, a domestic insurer shall include any person controlling a domestic insurer unless the person, as determined by the director, is either directly or through his affiliates primarily engaged in business other than the business of insurance. For the purposes of this section, “person” shall not include any securities broker holding, in the usual and customary broker’s function, less than twenty percent (20%) of the voting securities of an insurance company or of any person who controls an insurance company.

(2) The statement to be filed with the director as referenced in this section shall be made under oath or affirmation and shall contain the following:

(a) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) of this section is to be effected, hereinafter called the “acquiring party”; and

(i) If the person is an individual, his principal occupation and all offices and positions held during the past five (5) years and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(ii) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for the lesser period as the person and any predecessors shall have been in existence; a detailed description of the business intended to be conducted by the person and the person’s subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to such positions. The list shall include, for each individual, the information required by paragraph (a)(i) of this subsection; and

(iii) For individuals who are directors or executive officers of an entity, the information from time to time that is specified by the director on

the biographical affidavit form prescribed by the department of insurance;

(b) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction where funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing consideration;

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each acquiring party, or for such lesser period as the acquiring party and any predecessors shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement;

(d) Any plans or proposals that each acquiring party may have to liquidate the insurer, to sell the insurer's assets or merge or consolidate the insurer with any person, or to make any other material change in the insurer's business or corporate structure or management;

(e) The number of shares of any security referred to in subsection (1) of this section that each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (1) of this section, and a statement as to the method by which the fairness of the proposal was determined;

(f) The amount of each class of any security referred to in subsection (1) of this section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (1) of this section in which any acquiring party is involved including, but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description shall identify the persons with

whom the contracts, arrangements or understandings have been entered into;

(h) A description of the purchase of any security referred to in subsection (1) of this section during the twelve (12) calendar months preceding the filing of the statement required by this section by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(i) A description of any recommendations to purchase any security referred to in subsection (1) of this section made during the twelve (12) calendar months preceding the filing of the statement by any acquiring party or by anyone based upon interviews or at the suggestion of the acquiring party;

(j) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (1) of this section, and if distributed, of additional solicitation material relating thereto;

(k) The term of any agreement, contract or understanding made with, or proposed to be made with, any broker-dealer as to solicitation of securities referred to in subsection (1) of this section for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto;

(l) An agreement by the person required to file the statement referenced in subsection (1) of this section that it will provide the annual report specified in [section 41-3809\(12\), Idaho Code](#), for so long as its control exists;

(m) An acknowledgment by the person required to file the statement referenced in subsection (1) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the director upon request as necessary to evaluate enterprise risk to the insurer; and

(n) Such additional information as the director may prescribe by rule as necessary or appropriate for the protection of policyholders and security holders of the insurer or in the director's determination is in the public interest.

(3) If the person required to file the statement referenced in subsection (1) of this section is a partnership, limited partnership, syndicate or other group, the director may require that the information required by subsection (2)(a) through (n) of this section shall be provided to the director with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member or person is a corporation, or the person required to file the statement referenced in subsection (1) of this section is a corporation, the director may require that the information required by subsection (2)(a) through (n) of this section shall be provided to the director with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of the corporation.

(4) If any material change occurs in the facts set forth in the statement filed with the director and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the director and sent to the insurer within two (2) business days after the person learns of the change.

(5) If any offer, request, invitation, agreement or acquisition referenced in subsection (1) of this section is proposed to be made by means of a registration statement under the securities act of 1933, or in circumstances requiring the disclosure of similar information under the securities exchange act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) of this section may use the documents in furnishing the information required by that statement.

History.

I.C., § 41-3804, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

41-3804. Information as to tender offeror. [[I.C., § 41-3804](#), as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1993, ch. 194, § 18, effective July 1, 1993.]

Another former § 41-3804 was repealed. See Prior Laws, § 41-3801.

Federal References.

The securities act of 1933, referred to in subsection (5), is codified as [15 U.S.C.S. § 77a et seq.](#)

The securities exchange act of 1934, referred to in subsection (5), is codified as [15 U.S.C.S. § 78a et seq.](#)

§ 41-3805. Tender offer material. — All requests or invitations for tenders or advertisements making a tender offer or requesting or inviting tenders of such voting securities for control of a domestic insurer made by or on behalf of any person shall contain the information specified in [section 41-3804, Idaho Code](#), as the director may prescribe and shall be filed with the director at least ten (10) days prior to the time such material is first published or sent or provided to security holders. Copies of any additional material soliciting or requesting such tender offers subsequent to the initial solicitation or request shall contain information as the director may prescribe as necessary or appropriate in the public interest or for the protection of policyholders and stockholders and shall be filed with the director at least ten (10) days prior to the time copies of the material are first published or sent or provided to security holders.

History.

[I.C., § 41-3805](#), as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3805 was repealed. See Prior Laws, § 41-3801.

§ 41-3806. Approval by director — Hearings. — (1) The director shall approve any purchase, exchange, merger or other acquisition of control referred to in [section 41-3804\(1\), Idaho Code](#), or in [section 41-3824, Idaho Code](#), unless, after a public hearing, the director finds that:

(a) After the change of control, the domestic insurer referenced in [section 41-3804\(1\), Idaho Code](#), would be unable to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the purchase, exchange, merger or other acquisition of control would substantially lessen competition in the business of insurance in this state or tend to create a monopoly. In applying the competitive standard in this paragraph:

(i) The informational requirements of [section 41-3808\(3\)\(a\), Idaho Code](#), and the standards of [section 41-3808\(4\)\(b\), Idaho Code](#), shall apply;

(ii) The merger or other acquisition shall not be disapproved if the director finds that any of the situations meeting the criteria provided by [section 41-3808\(4\)\(c\), Idaho Code](#), exist; and

(iii) The director may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(c) The financial condition of any acquiring party may jeopardize the financial stability of the insurer or prejudice the interest of its policyholders or, in the case of an acquisition of control, the interest of any remaining stockholders who are unaffiliated with the acquiring person;

(d) The plans or proposals of the acquiring party to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and are not in the public interest;

(e) The competence, experience and integrity of the persons who would control the operation of the insurer are such that it would not be in the interest of policyholders and stockholders of the insurer or of the public to permit the merger or other acquisition of control; or

(f) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The public hearing referenced in subsection (1) of this section shall be held within thirty-five (35) days after the statement required by [section 41-3804\(1\), Idaho Code](#), is filed or as otherwise agreed to by the director and the person filing the statement, and at least twenty-one (21) days' notice of such hearing shall be given by the director to the person filing the statement. Not less than seven (7) days' notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the director. All discovery proceedings to the extent agreed to by the parties or allowed by the director shall be concluded not later than three (3) business days prior to the commencement of the public hearing. The director shall make a determination within fifty-six (56) days after conclusion of such hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and shall be entitled to conduct discovery proceedings in the same manner as allowed under chapter 2, title 41, Idaho Code, and applicable rules.

(3) If the proposed acquisition of control will require the approval of more than one (1) commissioner, the public hearing referenced in subsection (2) of this section may be held on a consolidated basis, upon written request to all affected commissioners by the person filing the statement referenced in [section 41-3804\(1\), Idaho Code](#). Such person shall file the statement referenced in [section 41-3804\(1\), Idaho Code](#), with the national association of insurance commissioners within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt-out within fourteen (14) days of the receipt of the statement referenced in [section 41-3804\(1\), Idaho Code](#). A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the

commissioners of the states in which the affected insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the director that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to section 41-3804(1)(a) of this chapter. Failure of the director to provide a determination within the prescribed time shall not negate the application of capital requirements otherwise required by title 41, Idaho Code, but may affect the time within which such requirements must be met.

(5) The director may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the director's staff as may be reasonably necessary to assist the director in reviewing the proposed acquisition of control. The director may require the acquiring party to post a bond in an amount not to exceed twenty-five thousand dollars (\$25,000) as security for payment of such expenses.

(6) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition that the director by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not anticipated by this section.

(7) The following shall be violations of this section:

(a) The failure to file any statement, amendment or other material required to be filed pursuant to the provisions of section 41-3804(1) or (2), Idaho Code; or

(b) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with a domestic insurer unless the director has given prior approval.

(8) The district courts of the state of Idaho are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the director under the

provisions of [section 41-3804, Idaho Code](#), and over all actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by the person of the director to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all lawful process shall be served on the director and transmitted by registered or certified mail by the director to the person at his last known address.

History.

[I.C., § 41-3806](#), as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3806 was repealed. See Prior Laws, § 41-3801.

Compiler's Notes.

For more information on the national association of insurance commissioners, referred to in subsection (3), see <http://naic.org/>.

§ 41-3807. Mailing — Payment of expenses. — (1) All notices of public hearings held pursuant to [section 41-3806, Idaho Code](#), shall be mailed by the insurer to its shareholders within five (5) business days after the insurer has received such notices. The expenses of such mailing shall be borne by the person making the filing. As security for the payment of such expenses, such person shall file with the director a bond or other deposit deemed acceptable and in an amount determined by the director.

(2) The provisions of this section shall not apply to any offers, requests, invitations, agreements or acquisitions by the person referred to in [section 41-3804, Idaho Code](#), of any voting security referred to in [section 41-3804, Idaho Code](#), which, immediately prior to the consummation of such offer, request, invitation, agreement or acquisition, was not issued and outstanding.

History.

[I.C., § 41-3807](#), as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3807 was repealed. See Prior Laws, § 41-3801.

§ 41-3808. Acquisitions involving insurers not otherwise covered. —

(1) The following definitions shall apply for the purposes of this section only:

(a) “Acquisition” means any agreement, arrangement or activity, the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers;

(b) “Involved insurer” means an insurer that either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

(2) This section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state. This section shall not apply to the following:

(a) An acquisition subject to approval or disapproval by the director pursuant to sections 41-3804 and 41-3806, Idaho Code;

(b) A purchase of securities solely for investment purposes, so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under the provisions of [section 41-3802\(2\), Idaho Code](#), it is not solely for investment purposes unless the commissioner of the insurer’s state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist, and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the director;

(c) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the director in accordance with subsection (3)(a) of this section thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section

if the acquisition would otherwise be excluded from this section by any other subsection of this section;

(d) The acquisition of already affiliated persons;

(e) An acquisition if, as an immediate result of the acquisition:

(i) In no market would the combined market share of the involved insurers exceeds [exceed] five percent (5%) of the total market;

(ii) There would be no increase in any market share; or

(iii) In no market would:

1. The combined market share of the involved insurers exceeds [exceed] twelve percent (12%) of the total market; and

2. The market share increases by more than two percent (2%) of the total market.

For the purpose of paragraph (e) of this subsection, a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(f) An acquisition for which a preacquisition notification would be required pursuant to the provisions of this section due solely to the resulting effect on the ocean marine insurance line of business; or

(g) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the director.

(3) An acquisition covered by subsection (2) of this section may be subject to the issuance of an order pursuant to subsection (5) of this section, unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification with the director. The director shall give confidential treatment

to information submitted under the provisions of this subsection in the same manner as provided in [section 41-3816, Idaho Code](#).

(a) The preacquisition notification shall be in such form and contain such information as prescribed by the director relating to those markets which, under subsection (2)(e) of this section, cause the acquisition not to be exempted from the provisions of this section. The director may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (4) of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his ability to render an informed opinion.

(b) The waiting period required shall begin on the date of receipt by the director of a preacquisition notification and shall end on the earlier of the thirtieth day after the date of receipt or termination of the waiting period by the director. Prior to the end of the waiting period, the director may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the director or termination of the waiting period by the director.

(4)(a) The director may enter an order under subsection (5)(a) of this section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly, or if the insurer fails to file adequate information in compliance with subsection (3) of this section.

(b) In determining whether a proposed acquisition would violate the competitive standard of paragraph (a) of this subsection, the director shall consider the following:

(i) Any acquisition covered under subsection (2) of this section involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standards.

1. If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A Insurer B

4% 4% or more

10% 2% or more

15% 1% or more

2. Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A Insurer B

5% 5% or more

10% 4% or more

15% 3% or more

19% 1% or more

A highly concentrated market is one in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two (2) insurers are involved, exceeding the total of the two (2) columns in the table is prima facie evidence of violation of the competitive standard in paragraph (a) of this subsection. For the purpose of this determination, the insurer with the largest share of the market shall be deemed to be insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection (2) of this section involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (a) of this subsection if:

1. There is a significant trend toward increased concentration in the market;
2. One (1) of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and
3. Another involved insurer's market is two percent (2%) or more.

(iii) For the purposes of paragraph (b) of this subsection:

1. "Insurer" means any company or group of companies under common management, ownership or control;
2. "Market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the director shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the national association of insurance commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, which line is that used in the annual statement required to be filed by insurers doing business in this state and the relevant geographical market is assumed to be this state;
3. The burden of showing prima facie evidence of violation of the competitive standard rests upon the director.

(iv) Even if an acquisition is not prima facie violative of the competitive standard under subsection (4)(b)(i) and (ii) of this section, the director may establish the requisite anticompetitive effect based upon other substantial evidence. Even if an acquisition is prima facie violative of the competitive standard under subsection (4)(b)(i) and (ii) of this section, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subsection include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

(c) An order may not be entered under subsection (5)(a) of this section if:

- (i) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits that would arise from such economies exceed the public benefits that would arise from not lessening competition; or
- (ii) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits that would arise from not lessening competition.

(5)(a) If an acquisition violates the provisions of this section, the director may enter an order:

- (i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or
- (ii) Denying the application of an acquired or acquiring insurer for a certificate of authority to do business in this state.

(b) Such an order shall not be entered unless:

- (i) A hearing has been held in accordance with chapter 2, title 41, Idaho Code;
- (ii) Notice of the hearing was issued prior to the end of the waiting period and not less than fourteen (14) days prior to the hearing; and
- (iii) The hearing was concluded and the order issued no later than fifty-six (56) days after the date of the filing of the preacquisition notification with the director.

Every order shall be accompanied by a written decision of the director setting forth findings of fact and conclusions of law.

(c) An order entered under the provisions of this subsection shall not become final earlier than twenty-eight (28) days after it is issued, during which time the involved insurer may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon such plan or other information, the director shall specify the conditions, if any, under the time period during which the aspects of the acquisition causing a violation of the provisions of this section would be remedied and the order vacated or modified.

(d) An order pursuant to this section shall not apply if the acquisition is not consummated.

(e) Any person who violates a cease and desist order of the director issued pursuant to subsection (5)(a) of this section and while the order is in effect may, after notice and the opportunity for a hearing and upon order of the director, be subject at the discretion of the director to one (1) or more of the following:

(i) A monetary penalty of not more than ten thousand dollars (\$10,000) for every day of violation; and/or

(ii) Suspension or revocation of the person's certificate of authority in this state.

(f) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than fifty thousand dollars (\$50,000).

(6) Sections 41-3818(2) and (3) and 41-3820, Idaho Code, do not apply to acquisitions covered under subsection (2) of this section.

History.

I.C., § 41-3808, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3808 was repealed. See Prior Laws, § 41-3801.

Compiler's Notes.

The bracketed insertions in paragraphs (2)(e)(i) and (2)(e)(iii)1. were added by the compiler to correct the enacting legislation.

For more on the national association of insurance commissioners, referred to in paragraph (4)(b)(iii)2., see <http://naic.org>.

§ 41-3809. Registration of holding company system insurers. — (1) Every insurer authorized to do business in this state and that is a member of an insurance holding company system shall register with the director, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile, which are substantially similar to those contained in this section and in:

- (a) Sections 41-3810(1), 41-3811 and 41-3812, Idaho Code; and
- (b) The provisions of [section 41-3810\(2\), Idaho Code](#), or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each change or addition.

Any insurer that is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter for the year ending December 31 immediately preceding, on the due date provided for filing of audited financial reports, or, if the insurer is not subject to filing of audited financial reports, on June 1, unless the director, for good cause shown, extends the time for registration, and then within the extended time. The director may require any insurer authorized to do business in the state that is a member of an insurance holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in subsection (3) of this section or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction. Upon request of the insurer or of the insurance regulatory authority of another jurisdiction in which the insurer is authorized to transact insurance, the director at the insurer's expense shall furnish a copy of the registration statement or other information filed by a domestic insurer with the director pursuant to this chapter.

(2) Every insurer subject to registration under this chapter shall file the registration statement with the director on a form and in a manner prescribed by the director. The registration statement shall contain the following current information:

- (a) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;
- (b) The identity and relationship of every member of the insurance holding company system;
- (c) The following agreements in force and transactions currently outstanding or that have occurred during the last calendar year between the insurer and its affiliates:
 - (i) Loans, other investments or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;
 - (ii) Purchases, sales or exchange of assets;
 - (iii) Transactions not in the ordinary course of business;
 - (iv) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;
 - (v) All management agreements, service contracts and all cost-sharing arrangements;
 - (vi) Reinsurance agreements;
 - (vii) Dividends and other distributions to shareholders; and
 - (viii) Consolidated tax allocation agreements.
- (d) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;
- (e) If requested by the director, the insurer shall provide to the director financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the U.S. securities and exchange commission (SEC) pursuant to the securities act of 1933, as amended, or the securities exchange act of 1934, as amended. An insurer required to file financial statements pursuant to this section may satisfy the request by providing the director with the most recently

filed parent corporation financial statements that have been filed with the SEC;

(f) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the director;

(g) Certification that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented and continue to maintain and monitor corporate governance and internal control procedures; and

(h) Any other information required by the director by statute or rule.

(3) All registration statements shall contain a summary outlining all items constituting changes from the prior registration statement.

(4) No information need be disclosed on the registration statement filed pursuant to subsection (2) of this section if the information is not material for the purposes of this section. Unless the director by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one percent (.5%) or less of an insurer's admitted assets as of the December 31 of the year immediately preceding shall not be deemed material for purposes of this chapter.

(5) Subject to [section 41-3810, Idaho Code](#), each registered insurer shall report to the director all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

(6) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this chapter.

(7) The director shall terminate the registration of any insurer that demonstrates that it no longer is a member of an insurance holding company system.

(8) The director may require or allow two (2) or more affiliated insurers subject to registration to file a consolidated registration statement.

(9) The director may allow any insurer that is authorized to do business in this state and that is part of an insurance holding company system, to register on behalf of any affiliated insurer that is required to register under subsection (1) of this section and to comply with all filing requirements under this chapter.

(10) The provisions of this section shall not apply to any insurer, information or transaction if and to the extent that the director by rule or order shall exempt the same from the provisions of this section. In considering whether to issue an exemption, the director may consider the following:

- (a) The size of the insurer and all affiliates;
- (b) The structure of ownership within the insurance holding company system;
- (c) The nature and amounts of transactions within the insurance holding company system;
- (d) The nature and complexity of the business of the insurer and affiliates; and
- (e) Any other factors the director deems appropriate.

Prior to issuing an exemption, the director shall notify all other insurance regulators where the insurer or its affiliates hold a certificate of authority.

(11) Any person may file with the director a disclaimer of affiliation with any authorized insurer, or such a disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the director, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party that the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing pursuant to chapter 2, title 41, Idaho Code, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the director, or if the disclaimer is deemed to have been approved.

(12) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state director of the insurance holding company system as determined by the procedures within the financial analysis handbook adopted by the national association of insurance commissioners.

(13) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required in this section within the time specified for filing shall be a violation of the provisions of this section.

History.

I.C., § 41-3809, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3809 was repealed. See Prior Laws, § 41-3801.

Federal References.

The securities act of 1933, referred to in paragraph (2)(e), is codified as 15 U.S.C.S. § 77a et seq.

The securities exchange act of 1934, referred to in paragraph (2)(e), is codified as 15 U.S.C.S. § 78a et seq.

For more on securities and exchange commission, referred to in paragraph (2)(e), see <http://www.sec.gov>.

Compiler's Notes.

For more information on the national association of insurance commissioners, referred to at the end of subsection (12), see <http://naic.org/>.

Section 36 of S.L. 1993, ch. 194 read: "For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date

of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

The abbreviations enclosed in parentheses so appeared in the law as enacted.

§ 41-3810. Standards and management of an insurer within an insurance holding company system. — (1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

- (a) The terms shall be fair and reasonable;
- (b) Agreements for cost-sharing services and management shall include such provisions as required by rule promulgated by the director;
- (c) Charges or fees for services performed shall be reasonable;
- (d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;
- (e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and
- (f) The insurer's surplus regarding policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs.

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, that are subject to any materiality standards contained in paragraphs (a) through (g) of this subsection, may not be entered into unless the insurer has notified the director in writing of its intention to enter into the transaction at least thirty (30) days prior thereto, or such shorter period as the director may permit, and the director has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported to the director within thirty (30) days after

the termination of a previously filed agreement, for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans, extensions of credit, guarantees or investments, provided the transactions are equal to or exceed:

(i) With respect to non-life insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus regarding policyholders as of December 31 of the year immediately preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of December 31 of the year immediately preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit, provided the transactions are equal to or exceed:

(i) With respect to non-life insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus regarding policyholders as of December 31 of the year immediately preceding;

(ii) With respect to life insurers, three percent (3%) of the insurer's admitted assets as of December 31 of the year immediately preceding;

(c) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements;

(ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities, in any of the next three (3) years, equals or exceeds five percent (5%) of the insurer's surplus regarding policyholders, as of December 31 of the year immediately preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and the nonaffiliate that any

portion of the assets will be transferred to one (1) or more affiliates of the insurer;

(d) All management agreements, service contracts, tax allocation agreements, guarantees and all cost-sharing arrangements;

(e) Guarantees when made by a domestic insurer, provided however, that a guarantee that is quantifiable as to amount is not subject to the notice requirement of this section, unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of surplus regarding policyholders as of December 31 of the year immediately preceding. Further, all guarantees that are not quantifiable as to amount are subject to the notice requirements of this section;

(f) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with the insurer's present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to [section 41-3803, Idaho Code](#), or authorized under any other section of this chapter, or in nonsubsidiary insurance affiliates that are subject to the provisions of this chapter, are exempt from this requirement; and

(g) Any material transactions, specified by statute or rule, that the director determines may adversely affect the interests of the insurer's policyholders.

Nothing in this section shall be deemed to authorize or permit any transactions that, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions that are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the director determines that separate transactions were entered into over any twelve (12) month period for that purpose, the director may exercise his authority pursuant to [section 41-3819, Idaho Code](#).

(4) The director, in reviewing transactions pursuant to subsection (2) of this section, shall consider whether the transactions comply with the

standards set forth in subsection (1) of this section and whether they may adversely affect the interests of policyholders.

(5) The director shall be notified within thirty (30) days of any investment of the domestic insurer in any one (1) corporation, if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

History.

I.C., § 41-3810, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3810 was repealed. See Prior Laws, § 41-3801.

§ 41-3811. Adequacy of surplus. — For purposes of this chapter, in determining whether an insurer's surplus regarding policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria; (2) The extent to which the insurer's business is diversified among several lines of insurance; (3) The number and size of risks insured in each line of business; (4) The extent of the geographical dispersion of the insurer's insured risks; (5) The nature and extent of the insurer's reinsurance program; (6) The quality, diversification and liquidity of the insurer's investment portfolio; (7) The recent past and projected future trend in the size of the insurer's investment portfolio; (8) The surplus regarding policyholders maintained by other comparable insurers; (9) The adequacy of the insurer's reserves;

(10) The quality and liquidity of investments in affiliates; the director may treat any investment in an affiliate as a disallowed asset for purposes of determining the adequacy of surplus regarding policyholders whenever in the judgment of the director the investment so warrants; and (11) The quality of the insurer's earnings and the extent to which the reported earnings include extraordinary items.

History.

I.C., § 41-3811, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3811 was repealed. See Prior Laws, § 41-3801.

§ 41-3812. Dividends and other distributions. — (1) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the director has received notice of the declaration thereof and has not within that period disapproved the payment, or until the director has approved the payment within the thirty (30) day period. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the greater of:

- (a) Ten percent (10%) of the insurer's surplus regarding policyholders as of December 31 of the year immediately preceding; or
- (b) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including net realized capital gains or losses, for the twelve (12) month period ending December 31 of the year immediately preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the director's approval, and the declaration shall confer no rights upon shareholders until the director has approved the payment of the dividend or distribution or until the director has not disapproved payment within the thirty (30) day period referred to in this subsection.

(2) Except as provided in this subsection, a domestic insurer shall not make any dividends except from earned surplus. A domestic insurer may declare and distribute a dividend from other than earned surplus if:

- (a) The director has given approval for the dividend prior to payment; and
- (b) Following payment of the dividend, the insurer's surplus regarding policyholders is:
 - (i) Reasonable in relation to its outstanding liabilities; and

(ii) Adequate to meet its financial needs.

(3) For purposes of subsection (2) of this section, “earned surplus” means unassigned funds as required to be reported on the insurer’s annual statement.

(4) A domestic insurer that is a member of a holding company system shall notify the director in writing of any nonextraordinary dividends to be paid or other distributions to be made to shareholders within five (5) business days following the declaration of the dividend or distribution, and shall notify the director in writing at least ten (10) days, commencing from the date of receipt by the director, prior to the payment of any dividends or the making of any other distribution.

History.

I.C., § 41-3812, as added by 2013, ch. 266, § 2, p. 652; am. 2017, ch. 95, § 1, p. 244; am. 2018, ch. 89, § 1, p. 194.

STATUTORY NOTES

Prior Laws.

Former § 41-3812. Jurisdiction of courts, which comprised I.C., § 41-3812, as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1993, ch. 194, § 26, effective July 1, 1993.

Another former § 41-3812 was repealed. See Prior Laws, § 41-3801.

Amendments.

The 2017 amendment, by ch. 95, substituted “net realized capital gains or losses” for “realized capital gains” in paragraph (1)(b) and in the last paragraph in subsection (1).

The 2018 amendment, by ch. 89, in subsection (1), substituted “greater” for “lesser” near the end of the introductory language, and deleted the former first and second sentences in the last paragraph which read: “In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carryforward shall be computed by taking the net income from the second

and third preceding calendar years, not including net realized capital gains or losses, less dividends paid in the second and immediate preceding calendar years”; inserted present subsections (2) and (3) and redesignated former subsection (2) as subsection (4).

§ 41-3813. Management of domestic insurers subject to registration.

— (1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this chapter.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one (1) or more other persons under arrangements meeting the standards of [section 41-3810\(1\), Idaho Code](#).

(3) Not less than one-third (1/3) of the directors of a domestic insurer, and not less than one-third (1/3) of the members of each committee of the board of directors of any domestic insurer, shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one (1) person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one (1) or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of subsections (3) and (4) of this section shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company or a publicly held corporation, has a board of directors and committees thereof that meet the requirements

of subsections (3) and (4) of this section with respect to such controlling entity.

(6) An insurer may make application to the director for a waiver from the requirements of this section, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the federal crop insurance corporation and national flood insurance program, is less than three hundred million dollars (\$300,000,000). An insurer may also make application to the director for a waiver from the requirements of this section based upon unique circumstances. The director may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members or the ownership or organizational structure of the entity.

History.

I.C., § 41-3813, as added by 2013, ch. 266, § 2, p. 652; am. 2014, ch. 97, § 27, p. 265.

STATUTORY NOTES

Prior Laws.

Former § 41-3813 was repealed. See Prior Laws, § 41-3801.

Amendments.

The 2014 amendment, by ch. 97, substituted “national flood insurance program” for “federal flood program” in the first sentence in subsection (6).

Compiler's Notes.

For more on federal crop insurance corporation, referred to in subsection (6), see <http://www.rma.usda.gov/fcic>.

For further information on the national flood insurance program, referred to in subsection (6), see <http://www.fema.gov/national-flood-insurance-program>.

§ 41-3814. Examination. — (1) Power of director. Subject to the limitation contained in this section and in addition to the authority the director has under chapter 2, title 41, Idaho Code, relating to the examination of insurers, the director shall have the power to examine any insurer registered under [section 41-3809, Idaho Code](#), and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(2) The director may order any insurer registered under [section 41-3809, Idaho Code](#), to produce such records, books or other information in the possession or control of the insurer or its affiliates as are reasonably necessary to determine compliance with this chapter. For such purpose, the director may order any insurer registered under [section 41-3809, Idaho Code](#), to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations or other method. In the event the insurer cannot obtain the information requested by the director, the insurer shall provide the director with a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the director that the detailed explanation is without merit, the director may require, after notice and the opportunity for a hearing, that the insurer pay a penalty in the amount and in the manner provided in [section 41-3819\(1\), Idaho Code](#), and may suspend or revoke the insurer's license.

(3) The director may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the director's staff as shall be reasonably necessary to assist in the conduct of the examination referenced in subsection (1) of this section. Persons so retained shall be under the direction and control of the director for the purposes stated herein and shall act in a purely advisory capacity.

(4) Each registered insurer producing for examination records, books and papers pursuant to subsection (1) of this section shall be liable for and shall

pay the expense of examination in accordance with the provisions of [section 41-228, Idaho Code](#), and applicable rules promulgated by the director.

(5) In the event the insurer fails to comply with an order issued by the director, the director shall have the power to examine the insurer's affiliates to obtain the information. The director shall also have the power to issue subpoenas, to administer oaths and to examine under oath any person for purposes of determining compliance with the provisions of this section. Upon the failure or refusal of any person to obey a subpoena issued by the director, the director may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obligated to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He shall be entitled to the same fees and mileage, if claimed, as a witness in the district court, which fees, mileage and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against and be paid by the company being examined.

History.

[I.C., § 41-3814](#), as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Cross References.

Contempt, § 7-601 et seq.

Fees and mileage of witnesses, § 9-1601 et seq.

Prior Laws.

Former § 41-3814, which comprised [I.C., § 41-3814](#), as added by 1972, ch. 163, § 1, p. 365, was repealed by S.L. 1993, ch. 194, § 27, effective July 1, 1993.

Another former § 41-3814 was repealed. See Prior Laws, § 41-3801.

§ 41-3815. Supervisory colleges. — (1) With respect to any insurer registered under [section 41-3809, Idaho Code](#), and in accordance with subsection (3) of this section, the director is authorized to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this chapter. The powers of the director with respect to supervisory colleges include, but are not limited to, the following:

(a) Initiating the establishment of a supervisory college; (b) Clarifying the membership and participation of other supervisors in the supervisory college; (c) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor; (d) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities and processes for information sharing; and (e) Establishing a crisis management plan.

(2) Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the director's participation in a supervisory college in accordance with subsection (3) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates and the director may establish a regular assessment to the insurer for the payment of these expenses.

(3) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with [section 41-3813, Idaho Code](#), the director may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The director may enter into agreements in accordance with [section 41-3816\(3\), Idaho Code](#), providing the basis for cooperation among the director and the other regulatory agencies, and the activities of

the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the director to regulate or supervise the insurer or its affiliates within its jurisdiction.

History.

I.C., § 41-3815, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3815 was repealed. See Prior Laws, § 41-3801.

§ 41-3815A. Group-wide supervision of internationally active insurance groups. — (1) The director is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the director may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

- (a) Does not have substantial insurance operations in the United States;
- (b) Has substantial insurance operations in the United States, but not in this state; or
- (c) Has substantial insurance operations in the United States and in this state, but the director has determined pursuant to the factors set forth in subsections (2) and (6) of this section that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the director make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

(2) In cooperation with other state, federal, and international regulatory agencies, the director will identify a single group-wide supervisor for an internationally active insurance group. The director may determine that the director is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the director may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The director shall consider the following factors when making a determination or acknowledgment under this subsection:

- (a) The place of domicile of the insurers within the internationally active insurance group who hold the largest share of the group's written premiums, assets, or liabilities;
- (b) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

(c) The location of the executive offices or largest operational offices of the internationally active insurance group;

(d) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the director determines to be:

(i) Substantially similar to the system of regulation provided under the laws of this state; or

(ii) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(e) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the director with reasonably reciprocal recognition and cooperation. However, a director or regulatory official from another jurisdiction identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in this subsection, shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and shall be made in consultation with the internationally active insurance group.

(3) Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the director shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

(a) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities; or

(b) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group,

the director shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to subsection (2) of this section.

(4) Pursuant to [section 41-3814, Idaho Code](#), the director is authorized to collect from any insurer registered pursuant to [section 41-3809, Idaho Code](#), all information necessary to determine whether the director may act as the group-wide supervisor of an internationally active insurance group or if the director may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the director, the director shall notify the insurer registered pursuant to [section 41-3809, Idaho Code](#), and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have no fewer than thirty (30) days to provide the director with additional information pertinent to the pending determination. The director shall publish on the department of insurance website the identity of internationally active insurance groups that the director has determined are subject to group-wide supervision by the director.

(5) If the director is the group-wide supervisor for an internationally active insurance group, the director is authorized to engage in any of the following group-wide supervision activities:

(a) Assess the enterprise risks within the internationally active insurance group to ensure that:

(i) The material financial condition and liquidity risks to the members of the internationally active insurance group engaged in the business of insurance are identified by management; and

(ii) Reasonable and effective mitigation measures are in place;

(b) Request, from any member of an internationally active insurance group subject to the director's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(i) Governance, risk assessment, and management;

(ii) Capital adequacy; and

(iii) Material intercompany transactions;

(c) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group engaged in the business of insurance;

(d) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of [section 41-3816, Idaho Code](#), through supervisory colleges as set forth in [section 41-3815, Idaho Code](#), or otherwise;

(e) Enter into agreements with or obtain documentation from any insurer registered under [section 41-3809, Idaho Code](#), any member of the internationally active insurance group and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the director's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(f) Other group-wide supervision activities, consistent with the authorities and purposes enumerated in this subsection, as considered necessary by the director.

(6) If the director acknowledges that another regulatory official from a jurisdiction that is not accredited by the national association of insurance commissioners is the group-wide supervisor, the director is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(a) The director's cooperation is in compliance with the laws of this state; and

(b) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the director's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the director is authorized to refuse recognition and cooperation.

(7) The director is authorized to enter into agreements with or obtain documentation from any insurer registered under [section 41-3809, Idaho Code](#), any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(8) The director may promulgate rules necessary for the administration of this section.

(9) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the director's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

History.

[I.C., § 41-3815A](#), as added by 2019, ch. 81, § 2, p. 188.

STATUTORY NOTES

Compiler's Notes.

The "s" enclosed in parentheses so appeared in the law as enacted.

Section 4 of S.L. 2019, ch. 81 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act."

§ 41-3816. Confidential treatment. — (1) Documents, materials or other information in the possession or control of the department that are obtained by or disclosed to the director or any other person in the course of an examination or investigation made pursuant to [section 41-3814, Idaho Code](#), and all information reported or provided to the department pursuant to sections 41-3804(2), 41-3809, 41-3810, and 41-3815A, Idaho Code, shall be confidential by law and privileged, shall be exempt from public disclosure, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use such documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains, unless the director, after giving the insurer and its affiliates who would be affected notice and opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication, in which event the director may publish all or any part in such manner as may be deemed appropriate.

(2) Neither the director nor any person who receives documents, materials or other information while acting under the authority of the director or with whom such documents, materials or other information is shared pursuant to this chapter, shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the director's duties under title 41, Idaho Code, the director:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other state, federal and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, including members of any

supervisory college described in [section 41-3815, Idaho Code](#), provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information and has verified in writing the legal authority to maintain confidentiality;

(b) Notwithstanding the provisions of subsection (3)(a) of this section, the director may only share confidential and privileged documents, materials or information reported pursuant to [section 41-3809\(12\), Idaho Code](#), with commissioners of states having statutes or regulations substantially similar to subsection (1) of this section and who have agreed in writing not to disclose such information;

(c) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(d) Shall enter into written agreements with the national association of insurance commissioners governing sharing and use of information provided pursuant to the provisions of this chapter consistent with this subsection, which agreements shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the national association of insurance commissioners and its affiliates and subsidiaries pursuant to this chapter, including procedures and protocols for sharing by the national association of insurance commissioners with other state, federal or international regulators;

(ii) Specify that ownership of information shared with the national association of insurance commissioners and its affiliates and subsidiaries pursuant to this chapter remains with the director, and the national association of insurance commissioners' use of the information is subject to the direction of the director;

(iii) Require prompt notice to be given to an insurer whose confidential information is in the possession of the national association of insurance commissioners pursuant to this chapter that disclosure of such confidential information has been requested or subpoenaed or otherwise sought; and

(iv) Require the national association of insurance commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial, administrative or similar action in which the national association of insurance commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the national association of insurance commissioners and the insurer's affiliates and subsidiaries pursuant to this chapter.

(4) The sharing of information by the director pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the director is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the director under the provisions of this section or as a result of sharing as authorized in subsection (3) of this section.

(6) Documents, materials or other information in the possession or control of the national association of insurance commissioners pursuant to this chapter shall be confidential and privileged, shall not be a public record, shall not be subject to public disclosure, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action.

History.

I.C., § 41-3816, as added by 2013, ch. 266, § 2, p. 652; am. 2019, ch. 81, § 3, p. 188.

STATUTORY NOTES

Prior Laws.

Former § 41-3816 was repealed. See Prior Laws, § 41-3801.

Amendments.

The 2019 amendment, by ch. 81, substituted “or provided to the department pursuant to sections 41-3804(2), 41-3809, 41-3810, and 41-3815A Idaho Code” for “pursuant to sections 41-3804(2), 41-3809 and 41-3810, Idaho Code” near the middle of the first sentence in subsection (1).

Compiler’s Notes.

For more on the national association of insurance commissioners, referred to throughout this section, see *<https://naic.org>*.

Section 4 of S.L. 2019, ch. 81 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

§ 41-3817. Rules. — The director may promulgate rules and issue orders as shall be necessary to carry out the provisions of this chapter.

History.

I.C., § 41-3817, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3817 was repealed. See Prior Laws, § 41-3801.

§ 41-3818. Injunctions, prohibitions against voting securities, sequestration of voting securities. — (1) Whenever it appears to the director that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of the provisions of this chapter or of any rule or order issued by the director hereunder, the director may apply to the district court, fourth judicial district for Ada county, for an order enjoining the insurer or director, officer, employee or agent thereof from violating or continuing to violate the provisions of this chapter or any rule or order thereunder, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

(2) No security that is the subject of any agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of the provisions of this chapter or of any rule or order issued by the director hereunder, may be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding; however, no action taken at any such meeting shall be invalidated by the voting of such securities, unless the action would materially affect control of the insurer or unless the courts of this state so order. If an insurer or the director has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this chapter or of any rule or order issued by the director hereunder, the insurer or the director may apply to the fourth judicial district court for Ada county to enjoin any offer, request, invitation, agreement or acquisition made in contravention of [section 41-3804, Idaho Code](#), or any rule or order issued by the director to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.

(3) In any case where a person has acquired or is proposing to acquire any voting securities in violation of the provisions of this chapter or any rule or order issued by the director hereunder, the fourth judicial district

court for Ada county, on such notice as the court deems appropriate, upon the application of the insurer or the director, shall seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue such order as may be appropriate to effectuate the provisions of this chapter.

(4) Notwithstanding any other provisions of law, for the purposes of this chapter, the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

History.

I.C., § 41-3818, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3818 was repealed. See Prior Laws, § 41-3801.

§ 41-3819. Sanctions. — (1) Any insurer failing, without just cause, to file any registration statement as required in this chapter shall be required, after notice and the opportunity for a hearing, to pay a penalty of two hundred dollars (\$200) for each day of delay, to be recovered by the director, and the penalty so received shall be distributed to the general fund of the state of Idaho. The maximum penalty under this section is ten thousand dollars (\$10,000). The director may reduce the penalty if the insurer demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the insurer.

(2) Every director or officer of an insurance holding company system who knowingly violates, participates in or assents to, or who knowingly permits any of the officers or agents of the insurer to engage in transactions or make investments that have not been properly reported or submitted pursuant to section 41-3809(1), 41-3810(2) or 41-3812, Idaho Code, or who violates the provisions of this chapter shall pay, in their individual capacity, an administrative penalty of not more than five thousand dollars (\$5,000) per violation, after notice and the opportunity for a hearing before the director. In determining the amount of the administrative penalty, the director shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of any previous violations and such other matters as the interests of justice may require.

(3) Whenever it appears to the director that any insurer subject to this chapter or any director, officer, employee or agent thereof has engaged in any transaction or entered into a contract that is subject to section 41-3810 or 41-3812, Idaho Code, and that would not have been approved had approval been requested, the director may order the insurer to cease and desist immediately from any further activity under that transaction or contract. After notice and the opportunity for a hearing, the director may also order the insurer to void any contracts and restore the status quo if such action is in the best interest of the policyholders, creditors or the public.

(4) Whenever it appears to the director that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this chapter, the director may seek criminal proceedings to be instituted by

referring the matter to the attorney general or the county prosecutor in the county in which the principal office of the insurer is located, or if the insurer has no office in this state, then in Ada county, Idaho, against the insurer or the responsible director, officer, employee or agent thereof. Any insurer who willfully violates the provisions of this chapter may be fined not more than five thousand dollars (\$5,000). Any individual who willfully violates the provisions of this chapter shall be guilty of a felony and may be imprisoned for not more than two (2) years or fined in his individual capacity not more than five thousand dollars (\$5,000), or both.

(5) Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the director in the performance of his duties under the provisions of this chapter, upon conviction shall be imprisoned for not more than three (3) years or fined five thousand dollars (\$5,000), or both. Any fines imposed shall be paid by the officer, director or employee in his individual capacity.

(6) Whenever it appears to the director that any person has committed a violation of the provisions of [section 41-3804, Idaho Code](#), and which prevents the director from fully understanding the enterprise risk to the insurer by affiliates or by the insurance holding company system, such violation may serve as an independent basis for the director's disapproval of dividends or distributions and for placing the insurer under an order of supervision in accordance with chapter 33, title 41, Idaho Code.

History.

[I.C., § 41-3819](#), as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

General fund, § 67-1205.

Prior Laws.

Former § 41-3819 was repealed. See Prior Laws, § 41-3801.

§ 41-3820. Receivership. — Whenever it appears to the director that any person has committed a violation of the provisions of this chapter that so impairs the financial condition of a domestic insurer as to threaten insolvency or make its further transaction of business hazardous to its policyholders, creditors, shareholders or the public, the director may proceed as provided in chapter 33, title 41, Idaho Code, to take possession of the property of the domestic insurer and to conduct its business in the capacity of a receiver.

History.

I.C., § 41-3820, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3820 was repealed. See Prior Laws, § 41-3801.

§ 41-3821. Recovery. — (1) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall be authorized to recover on behalf of the insurer:

(a) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock; or

(b) Any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee, where the distribution or payment pursuant to this subsection is made at any time during the one (1) year period preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (2), (3) and (4) of this section.

(2) No distribution shall be recoverable if the parent or affiliate of such domestic insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under subsection (1) of this section, that the person received. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable pursuant to this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(5) To the extent that any person liable under subsection (3) of this section is insolvent or otherwise fails to pay claims due pursuant to subsection (3) of this section, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

History.

I.C., § 41-3821, as added by 2013, ch. 266, § 2, p. 652.

STATUTORY NOTES

Prior Laws.

Former § 41-3821 was repealed. See Prior Laws, § 41-3801.

§ 41-3822. Revocation, suspension or nonrenewal of insurer's license.

— Whenever it appears to the director that any person has committed a violation of the provisions of this chapter that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the director may, after giving notice and the opportunity for a hearing, suspend, revoke or refuse to renew the insurer's license or certificate of authority to do business in this state for such period as the director finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

History.

I.C., § 41-3822, as added by 2013, ch. 266, § 2, p. 652.

§ 41-3823. Judicial review — Mandamus. — (1) Any person aggrieved by any act, determination, rule or order or any other action of the director pursuant to this chapter may appeal to the fourth judicial district court for Ada county, Idaho. The court shall conduct its review in accordance with the provisions of chapter 52, title 67, Idaho Code, or other applicable provisions of law.

(2) The filing of an appeal pursuant to this section shall stay the application of any rule, order or other action of the director to the party pursuing such appeal, unless the court, after providing the party with notice and the opportunity for a hearing, determines that a stay would be detrimental to the interest of policyholders, shareholders, creditors or the public.

(3) Any person aggrieved by any failure of the director to act or make a determination required by this chapter may petition the fourth judicial district court for Ada county for a writ in the nature of a mandamus or a peremptory mandamus directing the director to act or make a determination.

History.

I.C., § 41-3823, as added by 2013, ch. 266, § 2, p. 652.

§ 41-3824. Mutual insurance holding companies. —

(1)(a) A domestic mutual insurer, upon approval of the director, may reorganize by forming an insurance holding company system, which shall be designated as “a mutual insurance holding company,” based upon a mutual insurance company plan and continuing the corporate existence of the reorganizing insurer as a stock insurer. The director, after a public hearing as provided in [section 41-3806, Idaho Code](#), if satisfied that the interests of the policyholders are properly protected and that the plan of reorganization is fair and equitable to the policyholders, may approve the proposed plan of reorganization and may require as a condition of approval such modifications of the proposed plan of reorganization as the director finds necessary for the protection of the policyholders’ interests. The director may retain consultants for this purpose as provided in [section 41-3806\(5\), Idaho Code](#). A reorganization pursuant to this section is subject to the requirements of sections 41-3804 and 41-3805, Idaho Code. The director shall retain jurisdiction over a mutual insurance holding company organized pursuant to this section to assure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized insurer shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurer shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurer.

(2)(a) A domestic mutual insurer, upon the approval of the director, may reorganize by merging its policyholders’ membership interests into a mutual insurance holding company formed pursuant to subsection (1) of this section and continuing the corporate existence of the reorganizing insurer as a stock insurer subsidiary of the mutual insurance holding company. The director, after a public hearing as provided in [section 41-](#)

3806, Idaho Code, if satisfied that the interests of the policyholders are properly protected and that the merger is fair and equitable to the policyholders, may approve the proposed merger and may require as a condition of approval such modifications of the proposed merger as the director finds necessary for the protection of the policyholders' interests. For this purpose, the director may retain consultants as provided in section 41-3806(5), Idaho Code. A merger pursuant to this subsection is subject to sections 41-3804 and 41-3805, Idaho Code. The director shall retain jurisdiction over the mutual insurance holding company organized pursuant to this section to assure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized insurer shall be issued to the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting shares of the capital stock of the reorganized insurer. A merger of policyholders' membership interests in a mutual insurer into a mutual insurance holding company shall be deemed to be a merger of insurance companies pursuant to section 41-2857, Idaho Code, and is subject to the requirements of section 41-2857, Idaho Code.

(c) A foreign mutual insurer that is a domestic insurer organized under chapter 3, title 41, Idaho Code, may reorganize upon the approval of the director and in compliance with the requirements of any law or rule applicable to the foreign mutual insurer by merging its policyholders' membership interests into a mutual insurance holding company formed pursuant to subsection (1) of this section and continuing the corporate existence of the reorganizing foreign mutual insurer as a foreign stock insurer subsidiary of the mutual insurance holding company. The director, after a public hearing as provided in section 41-3806, Idaho Code, may approve the proposed merger. The director may retain consultants as provided in section 41-3806(5), Idaho Code. A merger pursuant to this paragraph is subject to the requirements of sections 41-3804 and 41-3805, Idaho Code. The reorganizing foreign mutual insurer

may remain a foreign company or foreign corporation after the merger and may be admitted to do business in this state, upon approval by the director. A foreign mutual insurer that is a party to the merger may at the same time redomesticate in this state by complying with the applicable requirements of this state and its state of domicile. The provisions of paragraph (b) of this subsection shall apply to a merger authorized under this paragraph.

(3) A mutual insurance holding company resulting from the reorganization of a domestic mutual insurer organized under chapter 21, title 30, Idaho Code, shall be incorporated pursuant to chapter 21, title 30, Idaho Code. This requirement shall supersede any conflicting provisions of chapter 21, title 30, Idaho Code. The articles of incorporation and any amendments to such articles of the mutual insurance holding company shall be subject to approval of the director in the same manner as those of an insurance company.

(4) A mutual insurance holding company is deemed to be an insurer subject to chapter 33, title 41, Idaho Code, and shall automatically be a party to any proceeding under chapter 33, title 41, Idaho Code, involving an insurer that, as a result of a reorganization pursuant to subsection (1) or (2) of this section, is a subsidiary of the mutual insurance holding company. In any proceeding under chapter 33, title 41, Idaho Code, involving the reorganized insurer, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized insurer for purposes of satisfying the claims of the reorganized insurer's policyholders. A mutual insurance holding company shall not be dissolved or liquidated without the prior approval of the director or as ordered by the district court pursuant to chapter 33, title 41, Idaho Code.

(5)(a) [Section 41-2855, Idaho Code](#), is not applicable to a reorganization or merger pursuant to this section.

(b) [Section 41-2855, Idaho Code](#), is applicable to demutualization of a mutual insurance holding company that resulted from the reorganization of a domestic mutual insurer organized pursuant to chapter 3, title 41, Idaho Code, as if the domestic mutual insurer were a mutual life insurer.

(6) A membership interest in a domestic mutual insurance holding company shall not constitute a security as defined in [section 30-14-102\(28\)](#),

Idaho Code.

(7) The majority of the voting shares of the capital stock of the reorganized insurer, which is required by this section to be at all times owned by a mutual insurance holding company, shall not be conveyed, transferred, assigned, pledged, subject to a security interest or lien, encumbered or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation or alienation of, in or on the majority of the voting shares of the reorganized insurer that is required by this section to be at all times owned by a mutual insurance holding company, is in violation of the provisions of this section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance or hypothecation or alienation, as to the shares necessary to constitute a majority of such voting shares. The majority of the voting shares of the capital stock of the reorganized insurer that is required by this section to be at all times owned by a mutual insurance holding company shall not be subject to execution and levy as provided in title 11, Idaho Code. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two (2) or more reorganized insurers or two (2) or more intermediate holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions and limitations as provided in this section to which the shares of the merging or consolidating reorganized insurers or intermediate holding companies were subject as provided in this section prior to the merger or consolidation.

(a) As used in this section, “majority of the voting shares of the capital stock of the reorganized insurer” means shares of the capital stock of the reorganized insurer that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized insurer for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized insurer. The ownership of a majority of the voting shares of the capital stock of the reorganized insurer that is required pursuant to this section to be at all times owned by a parent mutual insurance holding company includes indirect ownership through one (1) or more intermediate holding

companies in a corporate structure approved by the director. However, indirect ownership through one (1) or more intermediate holding companies shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the reorganized insurer. The director shall have jurisdiction over an intermediate holding company as if it were a mutual insurance holding company.

(b) As used in this section, “intermediate holding company” means a holding company that is a subsidiary of a mutual insurance holding company and that either directly or through a subsidiary intermediate holding company has one (1) or more subsidiary-reorganized insurers of which a majority of the voting shares of the capital stock would otherwise have been required pursuant to this section to be at all times owned by the mutual insurance holding company.

(8) It is the intent of the legislature that the formation of a mutual insurance holding company shall not increase the Idaho tax burden of the mutual insurance holding company system and that a stock insurance subsidiary shall continue to be subject to Idaho insurance premium taxation in lieu of all other taxes except real property taxes as provided in [section 41-405, Idaho Code](#). Subject to approval by the director as required under Idaho law, a stock insurance subsidiary may issue dividends or distributions to the mutual insurance holding company or any intermediate holding company and such dividends or distributions shall be excluded from the Idaho taxable income of the recipients; provided however, that such exclusion shall not apply if, in the year preceding the year in which the dividends or distributions were made, the subsidiary insurer’s liability for Idaho premium tax was less than the amount of Idaho income tax, computed after allowance for income tax credits, for which the insurer would have been liable in such year had the insurer been subject to Idaho income taxation rather than premium taxation.

History.

[I.C., § 41-3824](#), as added by 2013, ch. 266, § 2, p. 652; am. 2017, ch. 58, § 26, p. 91.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 58, substituted “chapter 21, title 30, Idaho Code” for “chapter 1, title 30, Idaho Code” three times in subsection (3).

§ 41-3825. Severability. — The provisions of this chapter are hereby declared to be severable and if any provision of this chapter or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this chapter.

History.

I.C., § 41-3825, as added by 2013, ch. 266, § 2, p. 652.

Chapter 39

MANAGED CARE REFORM

Sec.

41-3901. Short title.

41-3902. Intent and purpose.

41-3903. Definitions.

41-3904. Certificate of authority required — Exceptions — Application of certain provisions.

41-3905. Qualifications for certificate of authority.

41-3906. Application for certificate of authority.

41-3907, 41-3908. Issuance, refusal of certificate of authority — Expiration, continuation of certificate of authority. [Repealed.]

41-3909. Records.

41-3910. Reports to the director.

41-3911. Examinations.

41-3912. Suspension or revocation of certificate of authority.

41-3913. Powers of health maintenance organizations. [Repealed.]

41-3914. Annual disclosures.

41-3915. Health care contracts.

41-3916. Advisory panels.

41-3917. Certain words prohibited in name of organization.

41-3918. Grievance system.

41-3919. Open enrollment.

41-3920. Discrimination against health professionals associated with managed care organizations.

41-3921. Statutory construction and relationship to other laws.

41-3922. Taxation — Penalty for failure to file.

41-3923. Coverage of adopted newborn children — Coverage of maternity and complications of pregnancy.

41-3924. Limitation of benefits for elective abortions.

41-3925. Services provided by governmental entities.

41-3926. Mammography coverage.

41-3927. Health care providers — Participation by any qualified, willing provider — Contracts — Grievance procedure.

41-3928. Incentives to withhold care prohibited.

41-3929. Health insurance coverage for dependent children. [Repealed.]

41-3930. Utilization management program requirements.

41-3931. Participation in Idaho life and health insurance guaranty association.

41-3932. Exemptions from application of chapter.

41-3933. Subordinated indebtedness. [Repealed.]

41-3934. [Amended and Redesignated.]

41-3935. [Amended and Redesignated.]

41-3936. [Amended and Redesignated.]

41-3937. [Amended and Redesignated.]

41-3938. [Amended and Redesignated.]

41-3940. Preexisting conditions.

Idaho Code § 41-3901

§ 41-3901. Short title. — This chapter may be cited as the Idaho “Managed Care Reform Act.”

History.

1974, ch. 177, § 1, p. 1444; am. 1997, ch. 204, § 2, p. 579.

STATUTORY NOTES

Cross References.

Life and Health Insurance Guaranty Association Act, § 41-4301 et seq.

§ 41-3902. Intent and purpose. — As a guide to the interpretation and application of this chapter, the public policy of this state is declared as follows: The legislature wishes to eliminate legal barriers to the establishment of managed care plans which provide readily available, accessible and quality health care to their members and to encourage their development as an optional method of health care delivery. The state of Idaho must have reasonable assurance that organizations offering managed care plans within this state are financially and administratively sound and responsive to the needs of their members, and that such organizations are, in fact, able to deliver the benefits which they offer.

History.

1974, ch. 177, § 2, p. 1444; am. 1997, ch. 204, § 3, p. 579.

§ 41-3903. Definitions. — (1) “Basic health care services” means the following services: preventive care, emergency care, inpatient and outpatient hospital and physician care, hospital-based rehabilitation treatment, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

(2) “Coinsurance” means a percentage amount a member is responsible to pay out-of-pocket for health care services after satisfaction of any applicable deductibles or copayments, or both.

(3) “Copayment” means an amount a member must pay to a provider in payment for a specific health care service which is not fully prepaid.

(4) “Deductible” means the amount of expense a member must first incur before the managed care organization begins payment for covered services.

(5) “Director” means the director of the department of insurance of the state of Idaho.

(6) “Emergency facility” means any hospital or other facility where emergency services are provided to a member including, but not limited to, a physician’s office.

(7) “Emergency services” means those health care services that are provided in a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:

- (a) Placing the patient’s health in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

(8) “Employer” means any person, firm, corporation, partnership or association.

(9) “Enrollee” means a person who either individually or through a group has entered into a contract for services under a managed care plan.

(10) “General managed care plan” means a managed care plan which provides directly or arranges to provide, at a minimum, basic health care services. A general managed care plan shall include basic health care services.

(11) “Health care contract” means a contract entered into by a managed care organization and an enrollee.

(12) “Health care services” means those services offered or provided by health care facilities and health care providers relating to the prevention, cure or treatment of illness, injury or disease.

(13) “Limited managed care plan” means a managed care plan which provides dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services or such other services as the director may establish by rule to be limited health care services. Limited health care services shall not include hospital, medical, surgical or emergency services except as those services are provided incident to limited health care services.

(14) “Managed care organization” means a public or private person or organization which offers a managed care plan. Unless otherwise specifically stated, the provisions of this chapter shall apply to any person or organization offering a managed care plan, whether or not a certificate of authority to offer the plan is required under this chapter.

(15) “Managed care plan” means a contract of coverage given to an individual, family or group of covered individuals pursuant to which a member is entitled to receive a defined set of health care benefits through an organized system of health care providers in exchange for defined consideration and which requires the member to use, or creates financial incentives for the member to use, health care providers owned, managed, employed by or under contract with the managed care organization. A person holding a license to transact disability insurance offering a health plan that creates financial incentives to use contracting providers may elect to file the plan as a nonmanaged care plan not subject to the provisions of this chapter if the health plan reimburses providers solely on a fee for

service basis and does not require the selection of a primary care provider. The election to file a health plan as a nonmanaged care plan shall be made in writing at the time the plan is filed with the director pursuant to chapter 18, title 41, Idaho Code.

(16) “Member” means a policyholder, enrollee or other individual participating in a managed care plan.

(17) “Person” means any natural or artificial person including, but not limited to, individuals, partnerships, associations, corporations or other legally recognized entities.

(18) “Provider” means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

(19) “Utilization management program” means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a managed care plan using specified guidelines. Such a system may include, but is not limited to, preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures and retrospective review.

History.

I.C., § 41-3903, as added by 1997, ch. 204, § 5, p. 579; am. 1998, ch. 142, § 1, p. 505; am. 2004, ch. 283, § 2, p. 798.

STATUTORY NOTES

Prior Laws.

Former § 41-3903, which comprised 1974, ch. 177, § 3, p. 1444, was repealed by S.L. 1997, ch. 204, § 4, effective July 1, 1997.

Effective Dates.

Section 3 of S.L. 2004, ch. 283 provided: “This act shall be in full force and effect on and after July 1, 2004, and shall apply to health care policies renewing or written after July 1, 2004.”

CASE NOTES

Managed Care Organization.

Trial court erred in holding that the “any willing provider” statute, § 41-3927, was inapplicable to the physicians marketing network because the network was an inseparable part of a “managed care organization,” as defined in this section, the network was required to admit the cardiology company as a qualified willing provider. *Idaho Cardiology Assocs., P.A. v. Idaho Physicians Network, Inc.*, 141 Idaho 223, 108 P.3d 370 (2005).

§ 41-3904. Certificate of authority required — Exceptions — Application of certain provisions. — (1) No person shall in this state offer a managed care plan on a predetermined and prepaid basis, unless authorized under a certificate of authority issued by the director. A person offering a managed care plan on a predetermined and prepaid basis is deemed to be transacting the business of insurance.

(2) An organization proposing to offer a managed care plan on a predetermined and prepaid basis, after it has filed its application for a certificate of authority as provided in [section 41-3906, Idaho Code](#), and while its application is pending, if permitted by and in accordance with rules promulgated by the director, may inform the public concerning its proposed health care services.

(3) Entities not offering a managed care plan shall not be subject to the provisions of this chapter.

(4) An entity not required to obtain a certificate of authority which holds itself out to the public or markets itself as an organization rendering basic health care services to a specified population through a managed care plan shall be subject to and must comply with the following sections of this chapter but shall not be subject to regulation by the department: 41-3902; 41-3903; 41-3904; 41-3909(1) and (2); 41-3914(1) and (2); 41-3915(1), (2), (3), (4), (5), (6) and (8); 41-3916; 41-3917; 41-3918(1), (2) and (4); 41-3919(1) and (2); 41-3920; 41-3921(2), (3) [repealed] and (4) [now (3)]; 41-3922(2); 41-3926; 41-3927; 41-3928; 41-3930 and 41-3932, Idaho Code.

History.

1974, ch. 177, § 4, p. 1444; am. 1997, ch. 204, § 6, p. 579; am. 2003, ch. 304, § 14, p. 833.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions near the end of subsection (4) were added by the compiler to account for the 2015 amendment of § 41-3921.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3905. Qualifications for certificate of authority. — The director shall not issue or permit to remain in force a certificate of authority authorizing the transaction of managed care plans unless the organization offering the managed care plan is qualified therefor as follows:

(1) It must be empowered to engage in business as a managed care organization under its articles or certificate of incorporation, or of association, or partnership agreement, or other basic organizational document, as the case may be.

(2) It must be financially responsible, and have such funds and financial resources as may reasonably be expected to enable it to fulfill its obligations to its members. An organization offering a general managed care plan must comply with the capital and surplus requirements of a disability insurer under the provisions of [section 41-313, Idaho Code](#). The director shall determine the surplus required of an organization offering a limited managed care plan, which shall be not less than twenty-five thousand dollars (\$25,000) or such increased amount as the director may find reasonably necessary by the scope of the organization's proposed operations. As to financial resources of an organization offering a limited managed care plan the director may, among other relevant factors, also consider:

- (a) Any agreements with an insurer, professional service corporation, governmental agency, or other responsible organization to underwrite, insure payment for or provide the proposed services;
- (b) Agreements with providers for the provision of the proposed services;
- (c) Arrangements for liability insurance, or an adequate plan of self-insurance, as to claims for loss or injury arising out of managed care operations;
- (d) Reinsurance agreements; and
- (e) Deposit requirements under subsection (7) of this section.

(3) It must propose to provide health care services on a predetermined and prepaid basis and indemnity benefits covering all or a portion of the

cost of out-of-area services, out-of-network services and emergency services; provided, however, that except for care provided by primary care providers, who shall include at least those categories of providers listed in [section 41-3915\(2\)\(e\), Idaho Code](#), a managed care organization may require a determination that a member needs care from a category of provider not listed in [section 41-3915\(2\)\(e\), Idaho Code](#), before a member may access out-of-network nonemergency care from a provider not listed in [section 41-3915\(2\)\(e\), Idaho Code](#).

(4) It must have the intent to render and capability for rendering or providing coverage for good quality health care services, which will be and are readily available and accessible to members in each geographic area in which it proposes to operate or operates, and such services must be reasonably responsive to the needs of members.

(5) Its procedures for offering health care services, and for offering and terminating health care contracts, must be reasonable and equitable.

(6) It must propose to establish, and after authorization in fact establish and maintain, reasonable and adequate procedures to:

(a) Monitor the quality of health care provided, including a reasonable system of internal peer review of diagnosis and treatment of members' health conditions;

(b) Resolve grievances of members, as required by [section 41-3918, Idaho Code](#); and

(c) Provide members with an opportunity to participate in matters of policy and operation as required by [section 41-3916, Idaho Code](#).

(7) It must comply with the deposit requirements of section 41-316 or 41-316A, Idaho Code, as applicable; provided however, that the amount of the deposit required of an organization offering a limited managed care plan shall be not less than twenty-five thousand dollars (\$25,000) or such increased amount as the director may find reasonably necessary by the scope of the organization's proposed operations.

(8) Notwithstanding anything to the contrary in this chapter, the director may allow a period of up to three (3) years following the issuance of a certificate of authority to a managed care organization after the effective date of this act to comply with the capital, surplus and deposit requirements

of this chapter. The director shall establish minimum initial amounts and minimum increases in capital, surplus and deposits for such certificate holder based upon the number of enrolled members in its managed care plans. If the certificate holder fails to meet the capital, surplus or deposit requirements within the time herein allowed, the organization shall no longer be authorized to offer managed care plans on a predetermined and prepaid basis in this state. If the organization fails to meet the minimum increases established by the director, the organization shall cease to market its plans upon notice from the director.

(9) Notwithstanding anything to the contrary in this chapter, a managed care organization holding a valid Idaho certificate of authority to transact insurance as a health maintenance organization on or before the effective date of this act may have up to three (3) years from and after that date within which to comply with the increases in capital, surplus and deposit requirements imposed by this act. The director shall establish minimum increases in capital, surplus and deposits for the certificate holder based upon the number of enrolled members in its managed care plans. If the certificate holder fails to meet the capital, surplus or deposit requirements within the time herein allowed, the organization shall no longer be authorized to offer managed care plans on a predetermined and prepaid basis in this state. If the organization fails to meet the minimum increases established by the director, the organization shall cease to market its plans upon notice from the director.

History.

1974, ch. 177, § 5, p. 1444; am. 1997, ch. 204, § 7, p. 579; am. 2008, ch. 203, § 1, p. 651.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 203, in subsection (7), substituted “shall be not less than twenty-five thousand dollars (\$25,000) or such increased amount as the director may find reasonably necessary by the scope of the organization’s proposed operations” for “shall be equal to the surplus required of the organization pursuant to subsection (2) of this section.”

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The phrase “the effective date of this act” in subsections (8) and (9) refers to the effective date of S.L. 1997, Chapter 204, which was effective July 1, 1997.

The term “this act” at the end of the first sentence in subsection (9) refers to S.L. 1997, Chapter 204, which is codified as §§ 41-503, 41-3901 to 41-3906, 41-3909 to 41-3912, 41-3914 to 41-3928, and 41-3930 to 41-3932.

§ 41-3906. Application for certificate of authority. — (1) The application for a certificate of authority shall be in writing in the form prescribed by the director. It shall be verified by an officer of an applicant corporation or association, or member of an applicant firm, or by the applicant if an individual. The application shall set forth or be accompanied by:

- (a) a copy of the basic organizational document of the applicant, such as articles of incorporation or of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;
- (b) a copy of the bylaws, rules, or similar document regulating conduct of the applicant's internal affairs;
- (c) a listing of the names, addresses, principal occupations, and official positions of the individuals who are to be responsible for the conduct of applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;
- (d) a copy of any contract made or to be made between the applicant and any provider, and the applicant and any person named in subsection (c) hereof;
- (e) a statement generally describing the managed care organization, its health care plan or plans, facilities, and personnel;
- (f) a copy of each form of health care contract proposed to be issued;
- (g) financial statements showing the applicant's audited assets, liabilities, and sources and amount of financial support. A copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the director directs that additional or more recent financial information is required for proper administration of this chapter;
- (h) a financial plan, which includes a three (3) year projection of initial operating results anticipated, and a statement as to the sources of working

capital as well as any other source of funding;

(i) a description of the proposed method of marketing the plan;

(j) a statement of the geographic area or areas to be served;

(k) a description of the grievance procedures as required under [section 41-3918, Idaho Code](#);

(l) a description of the system and procedures for monitoring the quality of health care services as required by [section 41-3905\(6\)\(a\), Idaho Code](#);

(m) a description of the mechanism by which members will be given an opportunity to participate in matters of policy and operation as required by [section 41-3916, Idaho Code](#);

(n) if the applicant is not domiciled in this state, a power of attorney duly executed by the applicant and irrevocably appointing the director and his successors in office as the applicant's attorney upon whom may be served all lawful process in any legal action or proceeding against the managed care organization on a cause of action arising in this state; and

(o) such other information as the director may reasonably require as to the applicant's qualifications as a managed care organization.

(2) Every organization authorized to offer a managed care plan under a certificate of authority issued prior to July 1, 1997, shall comply with any new or additional requirements, other than applicable capital, surplus and deposit requirements, imposed by this act by January 1, 1998. If the organization does not comply by January 1, 1998, the organization shall no longer be authorized to offer managed care plans on a predetermined and prepaid basis in this state.

History.

1974, ch. 177, § 6, p. 1444; am. 1980, ch. 197, § 31, p. 433; am. 1997, ch. 204, § 8, p. 579.

STATUTORY NOTES

Compiler's Notes.

The term "this act" in subsection (2) refers to S.L. 1997, ch. 204, which is codified as §§ 41-503, 41-3901 to 41-3906, 41-3909 to 41-3912, 41-3914

to 41-3928, and 41-3930 to 41-3932.

Effective Dates.

Section 34 of S.L. 1980, ch. 197 read: “(1) Section 1 and sections 3 through 33 of this act shall be in full force and effect on and after July 1, 1980.

“(2) Section 2 of this act shall be in full force and effect on and after July 1, 1981.”

**§ 41-3907, 41-3908. Issuance, refusal of certificate of authority —
Expiration, continuation of certificate of authority. [Repealed.]**

STATUTORY NOTES

Compiler's Notes.

These sections, which comprised 1974, ch. 177, §§ 7 and 8, p. 1444, were repealed by S.L. 1997, ch. 204, § 9, effective July 1, 1997.

§ 41-3909. Records. — (1) Every managed care organization shall establish and at all times maintain adequate records of its financial and business transactions.

(2) The managed care organization shall retain its general records with respect to a particular transaction for a period of not less than seven (7) years after termination of the transaction, and health records shall be retained for a period of seven (7) years after the termination of the member's contract.

(3) The managed care organization shall make all records available to the director or his designee for review at all reasonable times upon the director's request; provided, however, that the availability of health records shall be subject to any Idaho law limiting or defining such availability.

History.

1974, ch. 177, § 9, p. 1444; am. 1997, ch. 204, § 10, p. 579.

STATUTORY NOTES

Compiler's Notes.

In this section "commissioner" has been changed to "director" on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3910. Reports to the director. — (1) Every managed care organization offering a managed care plan for which a certificate of authority is required shall annually, on or before the first day of June, file a report with the director showing its audited financial condition on the last day of the preceding December. The report shall be on forms prescribed by the director and shall be verified by an appropriate officer of the organization.

(2) Such report shall include:

(a) A financial statement of the organization, including its balance sheet and statement of income and expenditures for the preceding year certified by an independent public accountant;

(b) Any changes in the information submitted in connection with its application for certificate of authority;

(c) Such other information as is available to the managed care organization relating to the operations of the organization as the director may require by rule to enable him to carry out his duties under this chapter.

History.

1974, ch. 177, § 10, p. 1444; am. 1997, ch. 204, § 11, p. 579; am. 2008, ch. 203, § 2, p. 653.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 203, substituted “first day of June” for “first day of March” in subsection (1).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3911. Examinations. — (1) The director shall make an examination of the affairs and operations of any organization offering a managed care plan for which a certificate of authority is required as often as he deems necessary but not less frequently than once every five (5) years.

(2) Every such organization shall upon the director's request submit its books and records relating to its affairs and operations to such examination and shall facilitate the examination.

(3) Health records of individuals and records of providers providing services under a contract with the managed care organization shall not be subject to such examination, except as provided in [section 41-3909\(3\), Idaho Code](#).

(4) At the direction of the director, the expenses of examination shall be borne by the organization being examined in accordance with [section 41-228, Idaho Code](#).

History.

1974, ch. 177, § 11, p. 1444; am. 1997, ch. 204, § 12, p. 579; am. 2001, ch. 85, § 11, p. 211.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3912. Suspension or revocation of certificate of authority. — The director may initiate proceedings to suspend or revoke a certificate of authority to offer a managed care plan for the reasons and in the manner provided in title 41, Idaho Code, for mutual insurers. In addition to any other penalties, the director may impose a penalty upon the managed care organization of up to fifteen thousand dollars (\$15,000) for each and every unlawful act committed.

History.

I.C., § 41-3912, as added by 1997, ch. 204, § 14, p. 579.

STATUTORY NOTES

Prior Laws.

Former § 41-3912, which comprised 1974, ch. 177, § 12, p. 1444, was repealed by S.L. 1997, ch. 204, § 13, effective July 1, 1997.

§ 41-3913. Powers of health maintenance organizations. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1974, ch. 177, § 13, p. 1444, was repealed by S.L. 1997, ch. 204, § 15, effective July 1, 1997.

§ 41-3914. Annual disclosures. — (1) Every managed care organization shall provide to its enrollees and make available for inspection by the general public on an annual basis:

- (a) an audited statement of financial condition including a balance sheet and a summary of receipts and disbursements;
- (b) a description of the accessibility and availability of services, including a list of the providers currently participating in the managed care plan and of the providers who are accepting new patients, the addresses of primary care physicians and participating hospitals and the specialty of each physician and category of the other participating providers;
- (c) a statement as to whether the plan includes a limited formulary of medications, and a statement that the formulary will be made available to any prospective member or member upon request;
- (d) a clear and understandable description of the managed care organization's method of resolving member grievances;
- (e) a description of how the qualifications of participating providers may be obtained;
- (f) such other information as the director may by rule prescribe.

(2) In addition to matters specified in subsection (1) of this section, each managed care organization shall make available for public inspection a description of the benefit package or packages offered to each class of members and their rates. Such information shall be presented in clear, readable, and concise form and shall include, at a minimum, a description of all of the material elements required of health care contracts.

(3) A managed care organization for which a certificate of authority is required shall furnish a copy of the information required by this section to the department upon request of the director.

History.

1974, ch. 177, § 14, p. 1444; am. 1978, ch. 360, § 1, p. 947; am. 1997, ch. 204, § 16, p. 579; am. 2008, ch. 203, § 3, p. 653.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 203, added “upon request of the director” in subsection (3).

Effective Dates.

Section 2 of S.L. 1978, ch. 360, read: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval, and retroactively to January 1, 1978.” Approved March 29, 1978.

§ 41-3915. Health care contracts. — (1) All health care contracts or other marketing documents describing health care services offered by any managed care organization shall contain:

- (a) A complete description of the health care services and other benefits to which the member is entitled;
- (b) A description of the accessibility and availability of services, including a list of the providers participating in the managed care plan and of the providers who are accepting new patients, the addresses of primary care physicians and participating hospitals, and the specialty of each physician and category of the other participating providers. The information required by this subsection (1)(b) may be contained in a separate document and incorporated in the contract by reference and shall be amended from time to time as necessary to provide members with the most current information;
- (c) Any predetermined and prepaid rate of payment for health care services and for other benefits, if any, and any services or benefits for which the member is obliged to pay, including member responsibility for deductibles, copayments, and coinsurance;
- (d) All exclusions and limitations on services or other benefits including all restrictions relating to preexisting conditions;
- (e) A statement as to whether the plan includes a limited formulary of medications and a statement that the formulary will be made available to any member on request;
- (f) All criteria by which a member may be terminated or denied reenrollment;
- (g) Service priorities in case of epidemic, or other emergency conditions affecting demand for health care services;
- (h) A statement that members shall not, under any circumstances, be liable, assessable or in any way subject to payment for the debts, liabilities, insolvency, impairment or any other financial obligations of the managed care organization;

- (i) Grievance procedures;
- (j) Procedures for notifying enrollees of any change in benefits; and
- (k) A description of all prior authorization review procedures for health care services.

(2) In addition to the requirements of subsection (1) of this section, an organization offering a general managed care plan shall:

- (a) Establish procedures for members to select or change primary care providers;
- (b) Establish procedures to notify members of the termination of their primary care provider and the manner in which the managed care organization will assist members in transferring to another participating primary care provider;
- (c) Establish referral procedures for specialty care and procedures for after-hours, out-of-network, out-of-area and emergency care;
- (d) Allow members direct access to network obstetricians and gynecologists for maternity care, annual visits, and follow-up gynecological care for conditions diagnosed during maternity care or annual visits;
- (e) Allow family practice and general practice physicians, general internists, pediatricians, obstetricians, and gynecologists to be included in the general managed care plan's listing of primary care providers.

(3) No managed care organization shall cancel the enrollment of a member or refuse to transfer a member from a group to an individual basis for reasons relating to age, sex, race, religion, occupation, or health status. However, nothing contained herein shall prevent termination of a member who has violated any published policies of the organization, which have been approved by the director.

(4) No managed care organization shall contract with any provider under provisions which require a member to guarantee payment, other than specified copayments, deductibles and coinsurance to such provider in the event of nonpayment by the managed care organization for any services rendered under contract directly or indirectly between the member and the managed care organization.

(5) No health care provider shall require a member to make additional payments for covered services under a health care contract, other than specified deductibles, copayments, or coinsurance once a provider has agreed in writing to accept the managed care organization's reimbursement rate to provide a covered service.

(6) The rates charged by any managed care organization to its members shall not be excessive, inadequate, or unfairly discriminatory. The director may define by rule what constitutes excessive, inadequate or unfairly discriminatory rates and may require a description of the actuarial assumptions and analysis upon which such rates are based as well as whatever other information, available to the managed care organization, he deems necessary to determine that a rate or proposed rate meets the requirements of this subsection. If experience rating is a common health insurance practice in the area served by the managed care organization, it shall have the right to experience-rate its own contracts.

(7) No such contract form or amendment to an approved contract form shall be issued unless it has been filed with the director. The contract form or amendment shall become effective thirty (30) days after such filing unless specifically disapproved by the director. Any such disapproval shall be based on the requirements of [section 41-3905, Idaho Code](#), or subsection (1), (2), (4), (5) or (6) of this section.

(8) The director shall disapprove any contract which, with amendments, does not constitute the entire contractual obligation between the parties involved. No portion of the charter, bylaws, or other constituent document of the managed care organization shall constitute part of such a contract unless set forth in full therein or incorporated by reference as authorized in this section.

History.

1974, ch. 177, § 15, p. 1444; am. 1997, ch. 204, § 17, p. 579; am. 1998, ch. 421, § 1, p. 1329.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3916. Advisory panels. — Every managed care organization shall establish a mechanism to provide members an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other reasonable mechanisms. As a minimum, such an advisory panel shall be required to review and comment upon any proposed changes to: (a) the managed care plan's grievance procedures, and (b) nongroup member benefit packages and prepayments, prior to implementation of such policy. The substance of such comments shall be distributed to the affected members at the time notification of such policy changes are made.

History.

1974, ch. 177, § 16, p. 1444; am. 1978, ch. 361, § 1, p. 948; am. 1997, ch. 204, § 18, p. 579.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 1978, ch. 361, read: "An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval, and retroactively to January 1, 1978." Approved March 29, 1978.

§ 41-3917. Certain words prohibited in name of organization. — No person or organization offering a health care plan not qualified as a managed care plan under the provisions of this chapter shall use in its name, logo, contracts or literature the phrase, “health maintenance organization,” “managed care organization,” “general managed care organization” or “limited managed care organization” or the initials “HMO,” “MCO,” “GMCO,” or “LMCO.”

History.

1974, ch. 177, § 17, p. 1444; am. 1997, ch. 204, § 19, p. 579.

§ 41-3918. Grievance system. — (1) Every managed care organization shall establish a grievance system to resolve grievances initiated by members concerning health care services. The system shall provide reasonable procedures for the resolution of grievances, and shall include an appeals process which affords the member the right to a prompt review by a grievance panel before whom the member has the right either to appear or be heard, or both. A managed care organization offering a managed care plan for which a certificate of authority is required shall have its grievance system approved by the director and shall submit to the director an annual report in a form prescribed by the director which shall include:

- (a) A description of the procedures of the grievance system; and
- (b) The total number of grievances handled through the grievance system and a compilation of causes underlying the grievances filed.

(2) Every managed care organization shall maintain records of grievances filed with it concerning health care services and each managed care organization for which a certificate of authority is required shall submit to the director a summary report at such times and in such form as the director may require. Grievances involving other persons shall be referred to such persons with a copy to the director.

(3) The director may examine a grievance system of a managed care organization for which a certificate of authority is required, subject to the limitations concerning health records of individuals set forth in [section 41-3909\(3\), Idaho Code](#).

(4) Every managed care organization must show evidence that such grievance procedures have been reviewed and approved by the member representatives through their participation on advisory panels or other reasonable mechanisms as set forth in [section 41-3916, Idaho Code](#).

History.

1974, ch. 177, § 18, p. 1444; am. 1997, ch. 204, § 20, p. 579; am. 2008, ch. 203, § 4, p. 654.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 203, inserted “or other reasonable mechanisms” in subsection (4).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3919. Open enrollment. — (1) Requirement of an open enrollment period is intended to provide the benefits of managed care to the general public or to all members of the class of persons the managed care organization serves. Such requirement is not intended to prohibit a managed care organization from establishing administrative procedures that protect the quality of service to its members or the financial condition of the organization. However, during periods of open enrollment the organization shall not establish any administrative procedure that arbitrarily and unreasonably restricts enrollment.

(2) After the initial twenty-four (24) months of operation every managed care organization shall have an annual open enrollment period of at least one (1) month during which it accepts members, without restrictions up to the limits of its capacity except as provided in subsection (3) of this section, as determined by the managed care organization, in the order in which they apply for enrollment. Managed care organizations organized to provide services exclusively to a specified group or groups of individuals may limit such open enrollment to all members of such group(s).

(3) A managed care organization may apply to the director for authorization to impose underwriting restrictions upon enrollment. The director shall, within thirty (30) days, approve the application if he determines that such restrictions will: (a) Preserve the financial stability of the managed care organization; or (b) Prevent excessive adverse selection of prospective members; or (c) Avoid unreasonably high or unmarketable charges for member coverage for health care services.

If the application cannot be approved the director must deny it within the thirty (30) day period.

History.

1974, ch. 177, § 19, p. 1444; am. 1997, ch. 204, § 21, p. 579.

STATUTORY NOTES

Compiler's Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-3920. Discrimination against health professionals associated with managed care organizations. — It shall be unlawful for any health service institution or associations of health professionals to exclude other health professionals from working privileges, membership, or association solely on the basis that such other person is employed by or contracts with a managed care organization pursuant to this chapter.

History.

1974, ch. 177, § 20, p. 1444; am. 1997, ch. 204, § 22, p. 579.

§ 41-3921. Statutory construction and relationship to other laws. —

(1) Except as stated in this chapter, provisions of title 41, Idaho Code, applicable to disability insurers shall be applicable to the lawful transactions and business of an organization offering a managed care plan for which a certificate of authority is required pursuant to this chapter.

(2) With respect to all managed care organizations, the provision of factually accurate information regarding coverage, rates, locations and hours of service, names of affiliated institutions, and credentials of participating providers by the organization or its personnel to potential members shall not constitute a violation of any law relating to solicitation or advertising by health care professionals.

(3) Any managed care organization which contracts with a health care facility or enters into arrangements with one (1) or more groups of providers organized on a group practice or individual practice basis shall not by virtue of such contracts or arrangements be deemed to have entered into a “conspiracy in restraint of trade”.

(4) Except as expressly and specifically stated in this chapter, the provisions of chapter 34, title 41, Idaho Code, are not amended, repealed or otherwise affected by this chapter.

History.

1974, ch. 177, § 21, p. 1444; am. 1988, ch. 265, § 573, p. 549; am. 1997, ch. 204, § 23, p. 579; am. 2015, ch. 251, § 5, p. 1047.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 251, deleted former subsection (3), which read: “All managed care organizations and professionals associated with them shall be exempt from the provisions of [section 30-1315, Idaho Code](#), prohibiting persons from simultaneously being shareholders of more than one (1) professional service organization” and redesignated former subsections (4) and (5) as subsections (3) and (4).

Effective Dates.

Section 586 of S.L. 1988, ch. 265 provided that the act should become effective on and after January 1, 1989.

Section 10, S.L. 2015, ch. 251, provided that the act should take effect on and after July 1, 2015, and upon passage of Senate Bill No. 1025 (ch. 243), as enacted by the First Regular Session of the Sixty-third Idaho Legislature.

§ 41-3922. Taxation — Penalty for failure to file. — (1) Each organization offering a managed care plan for which a certificate of authority is required under this chapter shall be subject to taxation as provided in chapter 4, title 41, Idaho Code.

(2) Any managed care organization failing to file any documents required to be filed with the director by this chapter shall be liable to a fine of twenty-five dollars (\$25.00) for each day of delinquency. As applicable, the director shall suspend or revoke the certificate of authority of a delinquent managed care organization until the document is filed and the fine, if any, is fully paid.

History.

1974, ch. 177, § 28, p. 1444; am. 1978, ch. 9, § 2, p. 16; am. 1982, ch. 252, § 2, p. 643; am. and redesign. 1997, ch. 204, § 25, p. 579.

STATUTORY NOTES

Prior Laws.

Former § 41-3922, which comprised 1974, ch. 177, § 22, p. 1444; am. 1979, ch. 122, § 7, p. 375, was repealed by S.L. 1984, ch. 23, § 1.

Another former § 41-3922, which comprised I.C., § 41-3922, as added by 1984, ch. 23, § 8, p. 38, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

Compiler's Notes.

This section was formerly compiled as § 41-3928.

§ 41-3923. Coverage of adopted newborn children — Coverage of maternity and complications of pregnancy. — (1) Any contract delivered or issued for delivery in this state by an organization offering a managed care plan for which a certificate of authority is required, which provides coverage for injury or sickness for newborn dependent children of the members of the covered group, shall provide such coverage for such newborn children and infants, including adopted newborn children that are placed with the adoptive member of the covered group within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive member of the covered group more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive member of the covered group, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive member of the covered group signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a member of the covered group continues in the same manner as it would with respect to a naturally born child of the member of the covered group until the first to occur of the following events:

- (a) Date the child is removed permanently from that placement and the legal obligation terminates; or
- (b) The date the member of the covered group rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) The managed care organization shall not restrict coverage under a health care contract of any dependent child adopted by a member, or placed

with a member for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the member is eligible for coverage under the plan.

(3) Any new or renewing group disability insurance contract or blanket disability insurance contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half ($\frac{1}{2}$) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

(4) No health care contract which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, copayments, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan.

Where a plan which provides or arranges direct health care services for its members contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from prenatal care and delivery. However, expenses resulting from any delivery in excess of the deductible amount shall be treated as expenses for any other illness under the plan. If the pregnancy is interrupted, the maternity deductible charged for prenatal care and delivery shall be based on the value of the medical services received,

providing that it is never more than two-thirds (2/3) of the plan's maternity deductible.

This section shall apply to all health care contracts except any group health care contracts made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All health care contracts subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(5) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

History.

I.C., § 41-3932, as added by 1976, ch. 113, § 4, p. 443; am. 1993, ch. 305, § 4, p. 1129; am. 1994, ch. 365, § 8, p. 1144; am. and redesisg. 1997, ch. 204, § 26, p. 579; am. 1997, ch. 321, § 5, p. 948; am. 2009, ch. 125, § 5, p. 391.

STATUTORY NOTES

Prior Laws.

Former § 41-3923, which comprised 1974, ch. 177, § 23, p. 1444, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

Amendments.

This section was amended by two 1997 acts which appear to be compatible and have been compiled together.

The 1997 amendment, by ch. 204, § 26, redesignated the section which was formerly compiled as 41-3932 and in subsection (1) in the first

sentence following “Any” deleted “health maintenance organization”, added “by an organization offering a managed care plan for which a certificate of authority is required” following “in this state” and deleted “subscribers or other” or “subscriber or other” preceding “members” or “member” throughout the subsection; in subsection (2) substituted “The managed care” for “A health maintenance” at the beginning of the subsection, substituted “care” for “maintenance organization” following “coverage under a health” and substituted “member” for “participant or beneficiary” in three places; in subsection (3) in the first paragraph in the first sentence substituted “care” for “maintenance organization” following “No health”, deleted “on or after January 1, 1977” following “in this state” and added “copayments,” following “deductibles,”; and in subsection (3) in the third and last paragraphs substituted “care” for “maintenance organization” each time it appears.

The 1997 amendment, by ch. 321, § 5, added subsection (4).

The 2009 amendment, by ch. 125, added subsection (3) and redesignated the subsequent subsections accordingly.

Federal References.

The Newborns’ and Mothers’ Health Protection Act of 1996, referred to in subsection (5) of this section, is compiled as 42 U.S.C.S., §§ 300gg-4, 300gg-11 to 300gg-13, 300gg-21 to 300gg-23, 300gg-41 to 300gg-44, and 300gg-61 to 300gg-63.

Compiler’s Notes.

This section was formerly compiled as § 41-3932.

§ 41-3924. Limitation of benefits for elective abortions. — All policies, contracts, plans or certificates delivered, issued for delivery or renewed in this state by an organization offering a managed care plan for which a certificate of authority is required shall exclude coverage for elective abortions. Such exclusion may be waived by endorsement and the payment of a premium therefor. Availability of such coverage shall be at the option of the contractor. For purposes of this section, an “elective abortion” means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

History.

I.C., § 41-3934, as added by 1983, ch. 94, § 4, p. 206; am. and redesign. 1997, ch. 204, § 27, p. 579.

STATUTORY NOTES

Prior Laws.

Former § 41-3924, which comprised 1974, ch. 177, § 24, p. 1444, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

Compiler’s Notes.

This section was formerly compiled as § 41-3934.

§ 41-3925. Services provided by governmental entities. — (1) From and after July 1, 1990, no contract shall be issued in Idaho by an organization offering a managed care plan for which a certificate of authority is required which excludes from coverage services rendered the member while a resident in an Idaho state institution, provided the services to the member would be covered by the contract if rendered to him outside an Idaho state institution.

(2) From and after July 1, 1990, no contract issued by an organization offering a managed care plan for which a certificate of authority is required may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a contract which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of coverage under the managed care plan.

History.

I.C., § 41-3935, as added by 1990, ch. 300, § 4, p. 827; am. and redesign. 1997, ch. 204, § 28, p. 579.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Prior Laws.

Former § 41-3925, which comprised 1974, ch. 177, § 25, p. 1444, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

Compiler's Notes.

This section was formerly compiled as § 41-3935.

§ 41-3926. Mammography coverage. — (1) From and after July 1, 1992, all policies, contracts, plans or certificates issued by an organization offering a managed care plan which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:

- (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
- (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
- (c) A mammogram every year for any woman who is fifty (50) years of age or older.
- (d) A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

History.

I.C., § 41-3936, as added by 1992, ch. 132, § 4, p. 413; am. 1993, ch. 113, § 4, p. 288; am. and redesisg. 1997, ch. 204, § 29, p. 579.

STATUTORY NOTES

Prior Laws.

Former § 41-3926 which comprised 1974, ch. 77, § 26 was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

Compiler's Notes.

This section was formerly compiled as § 41-3936.

Effective Dates.

Section 6 of S.L. 1993, ch. 113 provided that the act shall be in full force and effect on July 1, 1993.

§ 41-3927. Health care providers — Participation by any qualified, willing provider — Contracts — Grievance procedure. — (1) Any managed care organization issuing benefits pursuant to the provisions of this chapter shall be ready and willing at all times to enter into care provider service agreements with all qualified providers of the category or categories which are necessary to provide the health care services covered by an organization if the health care providers: are qualified under the laws of the state of Idaho, desire to become participant providers of the organization, meet the requirements of the organization, and practice within the general area served by the organization.

(2) Nothing in this section shall preclude an organization from refusing to contract with a provider who is unqualified or who does not meet the terms and conditions of the organization's participating provider contract or from terminating or refusing to renew the contract of a health care provider who is unqualified or who does not comply with, or who refuses to comply with, the terms and conditions of the participating provider contract including, but not limited to, practice standards and quality requirements. The contract shall provide for written notice to the participating health care provider setting forth any breach of contract for which the organization proposes that the contract be terminated or not renewed and shall provide for a reasonable period of time for the participating health care provider to cure such breach prior to termination or nonrenewal. If the breach has not been cured within such period of time the contract may be terminated or not renewed. Provided however, that if the breach of contract for which the organization proposes that the contract be terminated or not renewed is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, the contract may be terminated or not renewed immediately.

(3) Every managed care organization issuing benefits pursuant to this chapter shall establish a grievance system for providers. Such grievance system shall provide for arbitration according to chapter 9, title 7, Idaho Code, or for such other system which provides reasonable due process provisions for the resolution of grievances and the protection of the rights of the parties.

(4) No managed care organization may require as an element of any provider contract that any person agree:

(a) To deny a member access to services not covered by the managed care plan if the member is informed that he will be responsible to pay for the noncovered services and the member nonetheless desires to obtain such services;

(b) To refrain from treating a member even at that member's request and expense if the provider had been, but is no longer, a contracting provider under the managed care plan and the provider has notified the member that the provider is no longer a contracting provider under the managed care plan;

(c) To the unnegotiated adjustment by the managed care organization of the provider's contractual reimbursement rate to equal the lowest reimbursement rate the provider has agreed to charge any other payor;

(d) To a requirement that the provider adjust, or enter into negotiations to adjust, his or her charges to the managed care organization if the provider agrees to charge another payor lower rates; or

(e) To a requirement that the provider disclose his or her contractual reimbursement rates from other payors.

(5) A managed care organization shall not refuse to contract with or compensate for covered services an otherwise eligible provider or nonparticipating provider solely because the provider has in good faith communicated with one (1) or more current, former, or prospective patient regarding the provisions, terms or requirements of the organization's products as they relate to the needs of the provider's patients.

(6) As part of a provider contract, a managed care organization may require a provider to indemnify and hold harmless the managed care organization under certain circumstances so long as the managed care organization also agrees to indemnify and hold harmless the provider under comparable circumstances.

(7) On request and within a reasonable time, a managed care organization shall make available to any party to a provider contract any documents referred to or adopted by reference in the contract except for information which is proprietary or a trade secret or confidential personnel records.

(8) A managed care organization shall permit a contracting provider who is practicing in conformity with community standards to advocate for his patient without being subject to termination or penalty for the sole reason of such advocacy.

(9) Subsections (1) and (2) of this section shall apply to provider participation contracts entered into after July 1, 1994.

History.

I.C., § 41-3937, as added by 1994, ch. 275, § 3, p. 853; am. and redesign. 1997, ch. 204, § 30, p. 579; am. 1998, ch. 422, § 1, p. 1332.

STATUTORY NOTES

Prior Laws.

Former § 41-3927, which comprised 1974, ch. 177, § 27, p. 1444, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

Compiler's Notes.

This section was formerly compiled as § 41-3937.

Two 1994 acts designated new sections as § 41-3937. Section 41-3937 as enacted by S.L. 1994, ch. 275, § 3 which was compiled as § 41-3937 was subsequently amended and redesignated as § 41-3927 by S.L. 1997, ch. 204, § 30, p. 579, while § 41-3937 as enacted by S.L. 1994, ch. 365, § 9 which was compiled as § 41-3938 was subsequently amended and redesignated as § 41-3929 by S.L. 1997, ch. 204, § 32.

CASE NOTES

Applicability.

Trial court erred in holding that this section was inapplicable to the physicians marketing network because the network was an inseparable part of a “managed care organization”. This section was applicable and required the network to admit the cardiology company as a qualified willing provider. **Idaho Cardiology Assocs., P.A. v. Idaho Physicians Network, Inc.**, 141 Idaho 223, 108 P.3d 370 (2005).

§ 41-3928. Incentives to withhold care prohibited. — (1) No managed care organization shall offer a provider and no contract between a managed care organization and a provider shall contain any incentive plan that includes a specific payment made, in any type or form, to the provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered by the health care contract and provided with respect to a specific member or group of members with similar medical conditions.

(2) Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are not tied to specific medical decisions involving specific members or groups of members with similar medical conditions.

History.

I.C., § 41-3928, as added by 1997, ch. 204, § 31, p. 579.

STATUTORY NOTES

Compiler's Notes.

Former § 41-3928 was amended and redesignated as § 41-3922 by § 25 of S.L. 1997, ch. 204, effective July 1, 1997.

**§ 41-3929. Health insurance coverage for dependent children.
[Repealed.]**

STATUTORY NOTES

Prior Laws.

Another § 41-3929, which comprised 1947, ch. 177, § 29, p. 1444, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

Compiler's Notes.

This section, which comprised I.C., § [41-3938] 41-3937, as added by 1994, ch. 365, § 9, p. 1144; am. and redesign. 1997, ch. 204, § 32, p. 579; am. 1998, ch. 292, § 25, p. 928, was repealed by S.L. 2003, ch. 304, § 1, effective July 1, 2003.

§ 41-3930. Utilization management program requirements. — (1) All managed care organizations performing utilization management or contracting with third parties for the performance of utilization management shall:

(a) Adopt utilization management criteria based on sound patient care and scientific principles developed in cooperation with licensed physicians and other providers as deemed appropriate by the managed care organization. Such criteria shall be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis;

(b) Adopt procedures for a timely review by a licensed physician, peer provider or peer review panel when a claim has been denied as not medically necessary or as experimental. The procedure shall provide for a written statement of the reasons the service was denied and transmittal of that information to the appropriate provider for inclusion in the member's permanent medical record;

(c) Upon enrollment, require members to provide written authorization for the release of medical information to the managed care organization;

(d) Adopt procedures which protect the confidentiality of patient health records. Such procedures may permit a managed care organization to record a telephone conversation in the course of requesting patient medical information only if it complies with existing state and federal laws and the other party to the conversation is notified by voice message that he is being recorded. Upon written request and within a reasonable time, a copy of such recordings shall be provided to the other party to the conversation if the recorded conversation becomes an issue in a formal grievance procedure, and the other party agrees to reimburse the managed care organization for reasonable costs associated with providing the requested copy.

(2) If emergency services are offered, no managed care organization shall require prior authorization for emergency services. In addition, a managed care organization shall respond to member or provider requests for prior authorization of a nonemergency service within two (2) business days after

complete member medical information is provided to the managed care organization unless exceptional circumstances warrant a longer period to evaluate a request. Qualified medical personnel shall be available during normal business hours for telephone responses to inquiries about medical necessity, including certification of continued length of stay.

(3) When prior approval for a covered service is required of and obtained by or on behalf of a member, the approval shall be final and may not be rescinded by the managed care organization after the covered service has been provided except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits or if the member for whom the prior approval was granted is not enrolled at the time the covered service was provided.

History.

I.C., § 41-3930, as added by 1997, ch. 204, § 33, p. 579.

STATUTORY NOTES

Prior Laws.

Former § 41-3930, which comprised 1974, ch. 177, § 30, p. 1444, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

§ 41-3931. Participation in Idaho life and health insurance guaranty association. — (1) Each organization offering a managed care plan for which a certificate of authority is required under this chapter shall, as a condition of its authority to offer managed care plans in this state, be a member insurer of the Idaho life and health insurance guaranty association established under chapter 43, title 41, Idaho Code.

(2) The director may take such actions and promulgate such rules as may be necessary to effectuate the provisions of this section.

History.

I.C., § 41-3931, as added by 1997, ch. 204, § 34, p. 579; am. 2000, ch. 371, § 2, p. 1224.

STATUTORY NOTES

Prior Laws.

Former § 41-3931, which comprised 1974, ch. 177, § 31, p. 1444; am. 1978, ch. 10, § 5, p. 19; am. 1990, ch. 285, § 5, p. 792; am. 1991, ch. 123, § 3, p. 268; am 1995, ch. 68, § 5, p. 173, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

§ 41-3932. Exemptions from application of chapter. — This chapter shall not apply to managed care programs operated under contract with the federal government under title XVIII of the federal social security act, as amended (medicare), or under contract with a plan otherwise exempt from operation of this chapter pursuant to the employee retirement income security act of 1974, as amended (ERISA). This chapter shall not apply to programs administered by the department of health and welfare under contract with the department of health and welfare under title XIX of the federal social security act, as amended (medicaid) or under programs administered by the department of health and welfare substance use disorder bureau or its contracted managed care organization.

History.

I.C., § 41-3932, as added by 1997, ch. 204, § 35, p. 579; am. 1997, ch. 321, § 5, p. 948; am. 2008, ch. 317, § 1, p. 879.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Amendments.

The 2008 amendment, by ch. 317, added “or under programs administered by the department of health and welfare substance use disorder bureau or its contracted managed care organization” at the end of the section.

Federal References.

Titles XVIII and XIX of the federal social security act, referred to in this section, are compiled as **42 U.S.C.S. § 1395 et seq.** and **42 U.S.C.S. § 1396 et seq.**, respectively.

The Employee Retirement Income Security Act of 1974 (ERISA) is compiled as **29 U.S.C.S. § 1001 et seq.**

Compiler’s Notes.

Former § 41-3932 was amended and redesignated as § 41-3923 by § 26 of S.L. 1997, ch. 204.

§ 41-3933. Subordinated indebtedness. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-3933, as added by 1977, ch. 131, § 1, p. 277, was repealed by S.L. 1997, ch. 204, § 24, effective July 1, 1997.

§ 41-3934. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-3924 by § 27 of S.L. 1997, ch. 204.

§ 41-3935. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-3925 by § 28 of S.L. 1997, ch. 204.

§ 41-3936. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-3926 by § 29 of S.L. 1997, ch. 204.

§ 41-3937. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-3927 by § 30 of S.L. 1997, ch. 204.

§ 41-3938. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

This section was amended and redesignated as § 41-3929 by § 32 of S.L. 1997, ch. 204 and then repealed by S.L. 2003, ch. 304, § 1, effective July 1, 2003.

§ 41-3940. Preexisting conditions. — A general managed care plan shall comply with the following provisions:

(1) A general managed care plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A general managed care plan shall not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(2) Genetic information shall not be considered as a condition described in subsection (1) of this section in the absence of a diagnosis of the condition related to such information.

(3) A managed care organization that does not use preexisting condition limitations in any of its general managed care plans may impose an affiliation period. "Affiliation period" means a period of time not to exceed sixty (60) days for new entrants and not to exceed ninety (90) days for late enrollees during which no premiums shall be collected and coverage issued shall not become effective. Such period shall begin on the enrollment date. This subsection does not preclude application of any waiting period applicable to all new enrollees under the general managed care plan, provided that any carrier-imposed waiting period is no longer than sixty (60) days and is used in lieu of a preexisting condition exclusion. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

History.

I.C., § 41-3940, as added by 1997, ch. 321, § 6, p. 948.

Chapter 40

SELF-FUNDED HEALTH CARE PLANS

Sec.

41-4001. Declaration of purpose.

41-4002. Definitions.

41-4003. Registration required — Exemptions — Not subject to insurance code.

41-4004. Plan requirements.

41-4005. Application for registration — Fee.

41-4006. Grant or denial of registration.

41-4007. Trust fund — Authority.

41-4008. Trust fund liability — Fiduciary funds.

41-4009. Investment of trust fund.

41-4010. Reserves and surplus.

41-4011. Records and accounts — Annual statement.

41-4012. Taxes.

41-4013. Examination of books, records and accounts.

41-4014. Trustees — Administrators — Bonding.

41-4015. Prohibited pecuniary interests in plan management.

41-4016. Political contributions prohibited.

41-4017. Recovery of depleted funds.

41-4018. Termination of registration.

41-4019. Liquidation of trust fund.

41-4020. Rules.

41-4021. Other provisions applicable.

41-4022. Penalties.

41-4023. Coverage from moment of birth — Complications of pregnancy.

41-4024. Services provided by governmental entities.

41-4025. Mammography coverage.

41-4026. Health insurance coverage for dependent children. [Repealed.]

§ 41-4001. Declaration of purpose. — (1) The purpose of this chapter is to recognize and provide reasonable supervision of self-funded or partially self-funded plans for provision of health care service benefits to employees or to students of a postsecondary educational institution in connection with or as an alternative to insurance and other prepayment plans, to provide standards for financial soundness of such plans, to protect the interests of employees or students covered thereby and to provide for the establishment of financially viable alternatives to traditional health care plans. The legislature of the state of Idaho declares that the existence and operation of such self-funded plans are matters of legislative concern, vitally affecting the rights and interests of the citizens of this state.

(2) The provisions of this chapter shall apply to any single employer or multiple employer plan or any postsecondary educational institution that provides a fully or partially self-funded health benefit plan for beneficiaries residing in this state to the extent that state regulation of such plan is not preempted by the employee retirement income security act of 1974, as amended.

History.

1974, ch. 248, § 1, p. 1624; am. 2006, ch. 414, § 1, p. 1257; am. 2013, ch. 181, § 1, p. 419.

STATUTORY NOTES

Cross References.

Life and Health Insurance Guaranty Association Act, § 41-4301 et seq.

Amendments.

The 2006 amendment, by ch. 414, added the subsection (1) designation; in subsection (1), substituted “chapter” for “act”, inserted “or partially self-funded”, deleted “and” preceding “to protect the interests” and inserted “and to provide for financially viable alternatives to traditional health care arrangements”; and added subsection (2).

The 2013 amendment, by ch. 181, inserted “or to students of a postsecondary educational institution,” “or students,” and “the establishment of” in the first sentence in subsection (1) and inserted “plan or any postsecondary educational institution that provides a” in subsection (2).

Federal References.

The employee retirement income security act of 1974, referred to in subsection (2), is compiled as [29 U.S.C.S. § 1001 et seq.](#)

§ 41-4002. Definitions. — For the purposes of this chapter unless context otherwise requires:

(1) “Administrator” is a person, if other than the trustee, employed or contracted by the trustee to provide administrative services to a self-funded plan.

(2) “Beneficiary” is any individual entitled, under the self-funded plan, to payment by the trust fund of any part or all of the cost of any health care service rendered to such beneficiary.

(3) “Claims liability” is the total of all incurred and unpaid claims, including incurred but not reported claims, for allowable benefits under a self-funded plan that are not reimbursed or reimbursable by stop-loss insurance provided by a carrier authorized to transact insurance in this state.

(4) “Contribution” is the amount paid or payable by the employer or employee, or a postsecondary educational institution or student, into the trust fund.

(5) “Department” is the Idaho department of insurance.

(6) “Director” is the director of the department of insurance.

(7) “Irrevocable trust agreement” is a trust agreement whereby under the terms thereof the plan sponsor cannot retain the power to alter, amend, revoke or terminate the transfer of funds or property held in trust.

(8) “Multiple employer welfare arrangement” or “multiple employer welfare plan” shall have the same meaning as that given to the term “multiple employer welfare arrangement” by the employee retirement income security act of 1974, as amended.

(9) “Person” is any individual, corporation, limited liability company, partnership, association, firm, syndicate, organization, educational institution or any other public or private entity organized or recognized under the laws of the state of Idaho.

(10) “Plan sponsor” is any person who creates a self-funded health benefit plan for the benefit of any employer and employee or employees, or

a postsecondary educational institution and student or students.

(11) “Postsecondary educational institution” is a person whose primary purpose is to provide a postsecondary education that offers or awards educational degrees and that provides courses or programs that lead to an educational degree, that is legally authorized and maintains a presence in the state of Idaho, and that has an average annualized enrollment of eight hundred (800) or more full-time students located in Idaho.

(12) “Public postsecondary educational institution” means Boise State University, Idaho State University, Lewis-Clark State College and the University of Idaho, along with the board of regents and board of trustees thereof.

(13) “Qualified actuary” is an actuary having experience in establishing rates for a self-funded plan and the health services being provided, and who is also a fellow of the society of actuaries, a member of the American academy of actuaries or an enrolled actuary under the employee retirement income security act of 1974, as amended.

(14) “Self-funded plan” or “plan” is any single employer plan, public postsecondary educational institution plan, or multiple employer welfare plan, or any other single or multiple employer plan, or any postsecondary educational institution student health benefit plan, other than a plan providing only benefits under title 72, Idaho Code, under which payment for medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by contributions or payments thereto by the employer or employers, or by the employer or employers and the employees, or by a postsecondary educational institution and students at said institution, or students of a postsecondary educational institution, who are not otherwise covered by insurance or contract with a health care service corporation or managed care organization authorized to transact business in this state.

(15) “Single employer” is any individual, sole proprietorship, business, partnership, corporation, limited liability company, firm or any other form of legally recognized entity or a group of two (2) or more employers under

“common control” as defined in section 3(40)(B)(iii) of the employee retirement income security act of 1974, as amended.

(16) “Student” is an individual enrolled in a postsecondary educational institution.

(17) “Surplus” is the excess of the assets of a self-funded plan minus the liabilities of the plan, provided the liabilities of a self-funded plan shall include the claims liability of the plan.

(18) “Trust fund” is a trust fund established in conjunction with a self-funded plan for receipt of contributions of employer and employees, postsecondary educational institution and students, and payment of or with respect to health care service costs of beneficiaries.

(19) “Trustee” is the trustee, whether a single or multiple trustee, of the trust fund.

History.

1974, ch. 248, § 2, p. 1624; am. 2006, ch. 414, § 2, p. 1257; am. 2013, ch. 181, § 2, p. 419; am. 2015, ch. 49, § 1, p. 107.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, added present subsections (5) to (8), (10) and (11) and renumbered the remaining subsections accordingly; substituted “chapter” for “act” in the introductory language; in subsection (1), inserted “appointed by the plan sponsor or” and substituted “provide administrative services to” for “administer”; deleted former subsection (3), which read: “Director’ is the director of the department of insurance of this state”; in present subsection (9), substituted “single or multiple employer welfare arrangement, or any other single or multiple employer plan, other than a plan providing only benefits under title 72, Idaho Code, under which payment for” for “plan under which payment for any disability income benefits not otherwise provided for under title 72, Idaho Code, (workmen’s compensation and related laws — industrial commission)”, inserted “or employers” twice following “employer”, and substituted “or managed care organization authorized to transact business in this state” for “health

maintenance organization, or similar other third party prepayment plan”; and substituted “in conjunction with” for “under” in present subsection (12).

The 2013 amendment, by ch. 181, added the definitions of department, irrevocable trust agreement, postsecondary education institution, qualified actuary, and student and their subsection designations; deleted “or ‘reserves’” following “Claims liability” in subsection (3); added “multiple employer welfare plan” to subsection (8); rewrote subsection (9) which read “Person’ is any individual, corporation, association, firm, syndicate, organization, or other entity”; inserted language relating to postsecondary educational institution and students throughout the section; and substituted “retirement income security act” for “retirement system act” in subsection (14).

The 2015 amendment, by ch. 49, added subsection (12) and redesignated the subsequent subsections accordingly; and, near the beginning of subsection (14), inserted “public postsecondary educational institution plan.”

Federal References.

The employee retirement income security act of 1974, referred to in subsections (8) and (13), is compiled as [29 U.S.C.S. § 1001 et seq.](#)

“Multiple employer welfare arrangement,” referred to in subsection (8), is defined for that act in [29 U.S.C.S. § 1002\(40\)](#).

“Common control,” referred to in subsection (15), is defined for that act in [29 USCS § 1002\(40\)\(B\)\(iii\)](#).

Compiler’s Notes.

For more on the society of actuaries, referred to in subsection (13), see <https://www.soa.org/Member/>.

For more on the American academy of actuaries, referred to in subsection (13), see <http://www.actuary.org/>.

The name of the commissioner of insurance has been changed to the director of the department of insurance on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4003. Registration required — Exemptions — Not subject to insurance code. — (1) No person shall offer or operate a self-funded plan in this state unless the plan is registered with the director as hereinafter provided.

(2) No registration shall be required of:

(a) Any self-funded plan established for the sole purpose of funding the dollar amount of a deductible clause contained in the provisions of an insurance contract issued by an insurer duly authorized to transact disability insurance in this state if the deductible does not exceed an amount applicable to each beneficiary of five thousand dollars (\$5,000) per annum and the total of all obligations to all beneficiaries insured under the plan arising out of the application of such a deductible does not exceed the aggregate amount of five hundred thousand dollars (\$500,000) in any one (1) year.

(b) Any plan established and maintained for the purpose of complying with any worker's compensation law or unemployment compensation disability insurance law.

(c) Any plan administered by or for the federal government, a federal agency, the state, or any county of this state.

(d) Any plan which is primarily for the purpose of providing first aid care and treatment by an employer for injury or sickness of employees while engaged in their employment.

(e) Any self-funded plan offering only dental and/or vision benefits, where such benefits are limited to no more than a total of five thousand dollars (\$5,000) per beneficiary per year. If self-funded dental and/or vision benefits are offered in conjunction with any other self-funded plan for disability or health benefits, the entire benefits are subject to all applicable provisions of chapter 40, title 41, Idaho Code, including registration.

(3) Plans that are registered under chapter 40, title 41, Idaho Code, shall not be deemed to be engaged in the business of insurance and shall not be subject to provisions of the Idaho insurance code except as expressly

provided in this chapter. A plan required to register with the department that operates in this state without registering under this chapter shall be deemed to be engaged in the business of insurance without authorization and any person offering or operating an unregistered plan shall be deemed to be transacting insurance without proper licensing and subject to all sanctions as provided by law.

(4) Any self-funded plan providing benefits to more than one (1) employer shall provide to each employer participant and to each prospective employer participant written notice that the plan is not insurance and does not participate in the Idaho life and health guaranty association. Any self-funded plan providing benefits to students of a postsecondary educational institution shall provide to each student participant and to each prospective student participant written notice that the plan is not insurance and does not participate in the Idaho life and health guaranty association. The notice shall also be included as part of all marketing materials used by or on behalf of the plan.

(5) Any plan registered as a single employer plan or as a multiple employer welfare plan shall not operate as or be registered as a postsecondary educational institution student health benefit plan. Any plan registered as a postsecondary educational institution student health benefit plan shall not operate as or be registered as a single employer plan or as a multiple employer welfare plan.

History.

1974, ch. 248, § 3, p. 1624; am. 2001, ch. 308, § 1, p. 1114; am. 2004, ch. 86, § 1, p. 321; am. 2006, ch. 414, § 3, p. 1257; am. 2013, ch. 181, § 3, p. 419; am. 2019, ch. 306, § 1, p. 915.

STATUTORY NOTES

Cross References.

Employment security law, § 72-1301 et seq.

Idaho life and health guaranty association, § 41-4301 et seq.

Worker's compensation law, § 72-101 et seq,

Amendments.

The 2006 amendment, by ch. 414, rewrote subsection (1), which formerly read: “No self-funded plan shall operate in this state except while registered with the director as hereinafter provided. Self-funded plans already in operation at the effective date of this act shall so register within ninety (90) days after such effective date”; deleted former subsection (1)(e), which read: “Any employer’s self-insured health plan or service established and maintained solely for its members and their immediate families, or to any self-insured health plan or service established, maintained, and insured jointly by any employer and any labor organization or organizations if such health plan or service has been in existence and operation for fifteen (15) years immediately preceding the effective date of this act”; substituted “this chapter. A plan that operates in this state without registering under this chapter shall be deemed to be engaged in the business of insurance and any person offering or operating an unregistered plan shall be deemed to be transacting insurance without proper licensing” for “this act” at the end of subsection (3); and added subsection (4).

The 2013 amendment, by ch. 181, in paragraph (2)(a), substituted “five thousand dollars (\$5,000)” for “two thousand dollars (\$2,000)” and “five hundred thousand dollars (\$500,000)” for “two hundred thousand dollars (\$200,000)”; added paragraph (2)(e); in subsection (3), inserted “under chapter 40, title 41, Idaho Code,” in the first sentence and “required to register with the department,” “without authorization,” and “and subject to all sanctions as provided by law” in the last sentence; inserted the second sentence in subsection (4); and added subsection (5).

The 2019 amendment, by ch. 306, substituted “or a federal agency, the state, or any county” for “or agency thereof or any county” in paragraph (2)(c).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4004. Plan requirements. — (1) The director shall not register any self-funded plan under this chapter unless the following requirements are met:

- (a) The plan must require all contributions to be paid in advance and to be deposited in and disbursed from a trust fund duly created by a written irrevocable trust agreement between the employer or employers and the trustee, or between the postsecondary educational institution and the trustee, that meets the terms of this chapter.
- (b) The plan shall appoint a trustee who demonstrates the character, fitness and competence to function in such role and whose function shall be to competently manage and administer the trust fund and plan.
- (c) With regard to single employer plans or multiple employer welfare plans, the plans must require that employers contribute to the trust fund and that all contributions by employees, if any, shall be by regular periodic payroll deductions, except as to contributions made by an employee during his absence from such employment for such period as the plan may reasonably provide.
- (d) The plan must provide that the trustee shall furnish to each employee-beneficiary or each student-beneficiary a copy of the plan, which shall include a written statement or schedule adequately and clearly stating all benefits currently provided under the plan, as well as all applicable restrictions, limitations, and exclusions, and the procedure for filing a claim for benefits.
- (e) The plan shall require that the trust fund be actuarially sound. Assets and income of the trust fund shall at all times be reasonably adequate to provide for full payment of all benefits promised to beneficiaries by the plan and to cover all other costs of operation. The initial contribution rates shall be calculated by a qualified actuary and shall include a reasonable provision for adverse deviation and a reasonable contribution to surplus.
- (f) Before the registration by the department of the self-funded plan, the department shall verify that an amount equal to fifty percent (50%) of the

qualified actuary's estimate of any minimum surplus requirements, as provided in [section 41-4010\(3\), Idaho Code](#), after twelve (12) months of operation, be deposited in the trust fund, in addition to the first month's contributions for all beneficiaries.

(2) After registration of the plan, in addition to the required quarterly and annual filings and other requirements as provided in this chapter, the trustee shall file the following documents with the director for his review and approval not less than thirty (30) days before the effective date thereof:

(a) An actuarial study as described in [section 41-4005\(2\)\(e\), Idaho Code](#), calculating new rates for the next plan year or more frequent period if there are any midterm rate changes;

(b) Any changes in the policy form, benefits or summary plan description;

(c) Any amendments or changes made to the stop-loss agreement or agreements, including change of carriers;

(d) Any amendments or changes made to administrative, service or management agreements;

(e) Any amendments or changes to the fidelity bond or other coverage the director deemed equivalent pursuant to [section 41-4014\(3\), Idaho Code](#);

(f) Any amendments or changes to the trust agreement; and

(g) Any change in the trustee or trustees, officers or management of the trust, which notice shall include biographical affidavits of any new trustee, officer or management personnel.

(3) The trustee shall notify the director immediately if the trustee learns or receives information that indicates that the surplus of the trust falls below the minimum surplus requirements.

History.

1974, ch. 248, § 4, p. 1624; am. 1990, ch. 169, § 1, p. 366; am. 2006, ch. 414, § 4, p. 1257; am. 2013, ch. 181, § 4, p. 419; am. 2019, ch. 306, § 2, p. 915.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, rewrote the section heading, which formerly read: “Qualifications for registration”; substituted “does not meet the following requirements” for “is not qualified therefor as follows” in the introductory language; inserted “The plan” at the beginning of subsections (1) to (4); inserted “that meets the terms of this chapter” at the end of subsection (1); in subsection (3), deleted “all such” after “require that”; in subsection (5), substituted “plan must require that the trust fund be” for “the trust fund must be” and deleted the last sentence, which formerly read: “In determining actuarial soundness the director shall also give due consideration to”; and deleted former subsections (5) and (6) which read:

“(5)(a) Applicable stop-loss insurance provided or to be provided the plan by an insurer duly authorized to transact disability insurance in this state;

“(b) Contracts with health care service corporations or health maintenance organizations authorized to conduct such operations in this state, and covering certain of the promised benefits;

“(c) Other applicable insurance or guarantys; and

“(d) Plan factors or provisions for prevention or reduction of adverse selection against the plan by those otherwise eligible to become beneficiaries.

“(6) Must otherwise be in compliance with this act”.

The 2013 amendment, by ch. 181, rewrote the section, adding paragraph (1)(f) and subsections (2) and (3).

The 2019 amendment, by ch. 306, substituted “estimate of any minimum surplus” for “estimate of the minimum surplus” near the middle of paragraph (1)(f).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4005. Application for registration — Fee. — (1) Application for registration of a self-funded plan shall be made to the director, on forms prescribed by the director, seeking such information concerning whether, in the opinion of the director, the plan is qualified for registration. The application shall require the applicant to designate whether the plan is applying for registration as a single employer plan or multiple employer welfare plan or as a postsecondary educational institution student health benefit plan. The application shall be signed and verified by at least one (1) employer or, if applicable, by a person authorized by a postsecondary educational institution to sign the application and at least one (1) plan trustee. If the employer, postsecondary educational institution, or trustee is a corporation, the verification shall be by a duly authorized corporate officer or by a managing member of the plan sponsor if the plan sponsor is a limited liability company.

(2) The application shall be accompanied by all plan documents including:

- (a) A copy of the irrevocable trust agreement under which the trust fund is to exist and operate;
- (b) A copy of the proposed written statement of benefits referenced in [section 41-4004\(1\)\(d\), Idaho Code](#);
- (c) A financial statement of the trust fund, if already in existence and operating at the time of application, certified by an independent certified public accountant. If the trust fund is not in existence at the time of application, a pro forma balance sheet for the start of operation of the plan and a pro forma balance sheet, by month, for the first twelve (12) months of operation of the plan shall accompany the application, provided that all balance sheets shall include actuarially determined claims liabilities;
- (d) A written statement of reasonably projected income and disbursements of the trust fund, by month, for the twelve (12) month period commencing with the effective date of registration of the trust

with the department and including changes to claims liabilities fully set forth in the monthly expenses as calculated by a qualified actuary;

(e) A copy of an actuarial study prepared by a qualified actuary certifying that the rates for the plan are sufficient to cover moderately adverse experience and all costs of operation. The study shall include the development and justification of the assumptions used by the actuary in determining the rates. The rates shall not be less than the sum of projected incurred claims for the year, plus costs of operation, plus any prior year deficiency, less any excess surplus prior to the establishment of the contribution deficit reserve;

(f) With regard to a single employer plan or a multiple employer welfare plan, if the plan is domiciled outside this state, a letter or other written evidence of good standing from the plan's regulator in the state of domicile;

(g) A copy of every contract between the plan and any administrator, trustee or service company;

(h) A copy of a stop-loss insurance agreement issued by an insurer authorized to do business in this state providing both specific and aggregate coverage in an amount as annually indicated in the actuarial opinion for the plan, provided the director may waive the requirements for aggregate stop-loss coverage if such coverage is not reasonably available or otherwise deemed appropriate;

(i) A copy of the policy, contract, certificate, summary plan description or other evidence of the benefits and coverages provided to beneficiaries, including a table of the rates charged or proposed to be charged for each form of such contract accompanied by a certification of a qualified actuary that:

(i) The rates are neither inadequate nor excessive nor unfairly discriminatory;

(ii) The rates are appropriate for the classes of risks for which they have been computed; and

(iii) An adequate description of the rating methodology has been filed with the director and the methodology follows consistent and equitable actuarial principles; and

(j) Such other relevant documentation and information as the director may reasonably require.

(3) The application shall be signed under oath by the plan sponsor or the trustee of the plan, and the application shall also include:

(a) A copy of any articles of incorporation and bylaws or any founding documents and bylaws of any entity acting as a plan sponsor;

(b) A list of the names, addresses and official capacities concerning the plan of the individuals who will be responsible for the management and conduct of the affairs of the plan, including all trustees, officers and directors. Biographical affidavits shall be submitted for all trustees and management personnel on a form prescribed by the director. Management personnel of the trust shall be experienced and competent to ensure the trust's compliance with Idaho laws and rules. Such individuals shall fully disclose the extent and nature of any contracts or arrangements between them and the plan, including any possible conflicts of interest; and

(c) A copy of the articles of incorporation, bylaws, if any, and irrevocable trust agreement of the plan, as well as any other document concerning the operation of the plan.

(4) At the time of filing the application the applicant shall pay to the director a nonrefundable filing fee as provided for by rule.

(5) The director shall transmit and account for all fees received by him hereunder as provided in [section 41-406, Idaho Code](#).

History.

1974, ch. 248, § 5, p. 1624; am. 1979, ch. 122, § 8, p. 375; am. 1984, ch. 23, § 12, p. 38; am. 2006, ch. 414, § 5, p. 1257; am. 2013, ch. 181, § 5, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, inserted “all plan documents including” at the end of the introductory language of subsection (2);

substituted “41-4004(4)” for “41-4004(5)” in subsection (2)(b); rewrote subsection (2)(c), which formerly read: “A financial statement of the trust fund, if already in existence and operating on the effective date [July 1, 1974] of this act, as of a date not more than forty-five (45) days prior to the date of filing the application. The statement shall be certified by an independent accountant, or by an accountant whose certification is acceptable to the director”; inserted “certified by a qualified actuary” at the end of subsection (2)(d); rewrote subsection (2)(e), which formerly read: “A copy of any study made of the proposed self-funded plan by any consultant for the information or guidance of employer or employees; and”; added present subsections (2)(f) to (2)(i)(iii) and redesignated former subsection (2)(f) as present subsection (2)(j); added present subsections (3) to (3)(c) and redesignated former subsections (3) and (4) as present subsections (4) and (5); and added present subsection (6).

The 2013 amendment, by ch. 181, rewrote the section, deleting former subsection (6), relating to qualified actuaries.

§ 41-4006. Grant or denial of registration. — (1) The director shall act upon an application for registration of a self-funded plan with all reasonable promptness, but not more than ninety (90) days from the date of submission of a complete application to the director. Failure to act within the ninety (90) day time period shall be deemed as registration of such self-funded plan by the director.

(2) The director may make such investigation of the application for registration as he deems advisable. If the director finds that the application is complete and that the plan meets the qualifications stated in sections 41-4004 and 41-4005, Idaho Code, and is otherwise consistent with the provisions of this chapter, he shall issue and deliver a certificate of registration in appropriate form to the applicant.

(3) In the event the director denies an applicant's application for registration, the director shall notify the applicant in writing of the basis for the denial. Within twenty-one (21) days of the issuance of the notice of denial, the applicant may submit to the director a written request for a hearing before the director or his duly appointed representative addressing the basis for the denial of the application and requesting that the director reexamine the applicant's qualifications for registration. An applicant's failure to request a hearing in writing within twenty-one (21) days of the issuance of the notice of denial shall be deemed a waiver of the opportunity for hearing.

History.

1974, ch. 248, § 6, p. 1624; am. 2006, ch. 414, § 6, p. 1257; am. 2013, ch. 181, § 6, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, inserted "but not less than ninety (90) days from the date of submission of a complete application to the director. Failure to act within the ninety (90) day time period shall be deemed to be the registration of such self-funded plan by the director. In the event the

director refuses to register the plan, the applicant shall be entitled to challenge such refusal pursuant to chapter 2, title 41, Idaho Code, and to the contested case and judicial review provisions of chapter 52, title 67, Idaho Code” at the end of the first sentence.

The 2013 amendment, by ch. 181, added the subsection designations; substituted “not more than ninety (90) days” for “not less than (90) days” in subsection (1); in subsection (2), added the section reference, “41-4005” and added “and is otherwise consistent with the provisions of this chapter”; added a subsection (3), which rewrote language which was formerly compiled at the end of present subsections (1) and (2).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4007. Trust fund — Authority. — The trust fund of a self-funded plan shall have the authority:

(1) To have and use an appropriate descriptive name; (2) To sue and be sued in its own name; (3) To contract in its own name. All such contracts shall be in writing and shall be signed by the trustee of the fund, and if there is more than one (1) trustee, the contract may be so executed by one (1) trustee if so authorized by all trustees; (4) To borrow money and give security therefor; and (5) To engage exclusively in transactions authorized or required by this chapter, or reasonably incidental thereto.

History.

1974, ch. 248, § 7, p. 1624; am. 2006, ch. 414, § 7, p. 1257; am. 2013, ch. 181, § 7, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, inserted “shall be” in subsection (3) and substituted “this chapter” for “this act” in subsection (5).

The 2013 amendment, by ch. 181, substituted “Authority” for “Powers” in the section heading and “the authority” for “power” in the introductory paragraph.

§ 41-4008. Trust fund liability — Fiduciary funds. — (1) The trust fund of a self-funded plan shall be legally liable for payment of all applicable benefits stated in the schedule of benefits for such plan in effect at the time a claim thereunder arises.

(2) Funds in the trust fund are fiduciary funds, and are not liable to any obligation of any plan sponsor, including any employer participant or postsecondary educational institution, nor are fiduciary funds held in the trust subject to garnishment or levy. The prohibition on garnishment or levy shall not be deemed to prohibit levy upon the trust fund by any provider thereof (or its assignee) for health care services rendered to a beneficiary.

(3) All funds and moneys received by the self-funded plan and all funds billed and paid as contributions to the trust fund shall be timely deposited in the trust account and shall be held in no other name than the name of the self-funded plan.

History.

1974, ch. 248, § 8, p. 1624; am. 2013, ch. 181, § 8, p. 419.

STATUTORY NOTES

Amendments.

The 2013 amendment, by ch. 181, added “Fiduciary funds” in the section heading; rewrote subsection (2), which formerly read: “Funds in the trust fund are fiduciary funds, and are not liable for any obligation of any employer participant in the plan, nor subject to garnishment or levy for the obligation of any beneficiary. This clause shall not be deemed to prohibit levy upon the trust fund by any provider thereof (or its assignee) for health care services rendered a beneficiary if the trust fund has theretofore agreed in writing to pay for the same direct to such provider”; and added subsection (3).

Compiler’s Notes.

The words in parentheses so appeared in the law as enacted.

§ 41-4009. Investment of trust fund. — (1) The trustee may invest trust funds available for that purpose in the following kinds of investments only:

(a) General obligations of the United States government, or of any state, district, commonwealth, or territory of the United States, or of any municipality, county, or other political subdivision or agency thereof.

(b) Obligations, including the payment of principal and interest thereon of which are guaranteed by any such government or agency.

(c) Corporate bonds and similar obligations meeting the requirements specified for investment of funds of insurers under [section 41-711, Idaho Code](#).

(d) Collateral loans, including payment of principal and interest of which are adequately secured by securities in which the trust fund could lawfully invest directly.

(e) Deposits, savings accounts, and share accounts in chartered banks and savings and loan associations located in the United States. An investment in any one (1) such institution may not be in excess of the amount covered by applicable deposit, savings, and share account insurance, unless otherwise authorized by the director.

(f) Investments as permitted by sections 41-714 and 41-716, Idaho Code, provided that the combined amount of such investments shall not exceed ten percent (10%) of the total assets of the trust fund.

(2) In addition to investments excluded under subsection (1) of this section, the trustee is expressly prohibited from investing trust fund moneys in:

(a) Any loan to or security of any plan sponsor including any employer or postsecondary educational institution participating in the plan, or to or of any trustee, officer, director, subsidiary or affiliate of any such plan sponsor, employer or postsecondary educational institution.

(b) The security of any person in which the trustee, administrator, or any consultant of the plan has a direct or indirect material pecuniary interest.

(c) Real property or loans thereon.

(d) Any personal loan.

(3) All such investments shall be made and held in the name of the trust fund, and the interest and yield thereon shall inure to the benefit of the trust fund.

(4) No investment shall be made by or on behalf of the trust fund unless authorized in writing by the trustee and included in the records of the trust fund.

(5) Any person who authorizes any investment of trust fund moneys in violation of this section shall, in addition to other penalties that may be applicable therefor, be liable for all loss suffered by the trust fund on account of the investment.

(6) No investment made in violation of this section shall constitute an “asset” in any determination of the financial condition of the trust fund.

History.

1974, ch. 248, § 9, p. 1624; am. 2006, ch. 414, § 8, p. 1257; am. 2013, ch. 181, § 9, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, in subsection (1)(e), substituted “may” for “shall not” and inserted “at the discretion of the director”; and added present subsection (1)(f).

The 2013 amendment, by ch. 181, in subsection (2), rewrote (a), which formerly read: “Any loan to or security of any employer participating in the plan, or to or of any officer, director, subsidiary or affiliate of any such employer” and rewrote (d), which formerly read: “Any personal loan, other than a collateral loan referred to in subsection (1)(d) of this section, but subject to paragraphs (a) and (b) of this subsection (2)”; added “by or on behalf of the trust fund” in subsection (4); and made stylistic changes throughout.

§ 41-4010. Reserves and surplus. — (1) The trustee of a self-funded plan shall establish and maintain in the trust fund the following reserves:

(a) A reserve in an amount as certified by a qualified actuary as being necessary for payment of claims liability. The reserve shall be reasonably adjusted on a quarterly basis in an amount as determined by a qualified actuary or other qualified person if authorized by the director.

(b) If, under the plan, periodic contributions to the trust fund have been paid in advance or are payable less frequently than monthly, there shall be a reserve for unearned contributions as computed pro rata on the basis of the unexpired portion of the period for which the contribution has been paid.

(c) If future claims payments plus future costs of operation are greater than future contributions plus current reserves, there shall be a reserve in an amount equal to future claims payments plus future costs of operation, less future contributions, less current reserves.

(2) In any determination of the financial condition of the trust fund, the claims reserve, reserve for unearned contributions and contribution deficiency reserve shall constitute liabilities.

(3)(a) In addition to reserves required by this section, a self-funded plan shall establish and maintain in its trust fund surplus equal to at least:

(i) The equivalence of three (3) months of contributions for the current plan year; or

(ii) One hundred ten percent (110%) of the difference between the total dollar aggregate stop-loss attachment point plus costs of operation and the total dollar expected contributions for the current plan year.

(b) Paragraph (a) of this subsection notwithstanding, a public postsecondary educational institution shall instead be required to establish and maintain in its trust fund surplus an amount equal to at least thirty percent (30%) of the unpaid claims liability of the plan.

(c) Upon request of a self-funded plan, the director may annually waive the surplus requirement provided in paragraph (a) or (b) of this

subsection if:

- (i) The plan or trust carries insurance providing aggregate coverage and specific coverage;
- (ii) The plan, in its first year of operation, receives periodic contributions, at minimum on a monthly basis, at an amount at least equal to the point at which the insurance providing aggregate coverage must cover at least one hundred percent (100%) of the plan's liability, as certified by a qualified actuary; and
- (iii) In its second and each subsequent year of operation, the plan:
 - 1. Continues to provide stop-loss coverage as described in subparagraph (i) of this paragraph; or
 - 2. Is funded, at minimum on a monthly basis, at an amount equal to at least one hundred percent (100%) of the self-funded plan's liability, less any surplus as defined in [section 41-4002, Idaho Code](#), from previous years.

The director may also waive any or all requirements provided in subparagraphs (i) through (iii) of this paragraph, provided that the plan maintains reserves and surplus, as defined in [section 41-4002, Idaho Code](#), of at least the amount certified annually by a qualified actuary as sufficient without aggregate coverage.

(4) A surplus note that has been approved by the director in a form and as defined in [section 41-2841, Idaho Code](#), may be used to fund surplus and shall not be accounted as a liability.

(5) Up to one-third (1/3) of the surplus required by this section may be funded by a clean, irrevocable letter of credit, in a form acceptable to the director, issued in favor of the trust fund by a federally or state-chartered bank having a branch office in Idaho. Such irrevocable letter of credit cannot be guaranteed by pledge of any of the plan assets. The funding cannot be in the form of prepaid contributions or other loan or associated with an offsetting liability.

(6) A newly formed plan with no prior operating history shall meet the minimum surplus requirements no later than twelve (12) months after the date of initial operation. The director may extend for a reasonable period

not to exceed twelve (12) additional months, provided that the plan is meeting all other provisions of this chapter. For plans registered with the department and in existence on the effective date of this law, such plans shall have twenty-four (24) months from the effective date of this law in which to increase their surplus level to comply with the requirements of subsection (3) of this section.

(7) The trust fund shall maintain the minimum surplus requirements at all times throughout the year.

History.

1974, ch. 248, § 10, p. 1624; am. 2006, ch. 414, § 9, p. 1257; am. 2013, ch. 181, § 10, p. 419; am. 2015, ch. 49, § 2, p. 107; am. 2017, ch. 179, § 1, p. 410; am. 2019, ch. 306, § 3, p. 915.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, inserted “and surplus” to the end of the section heading; inserted “in the trust fund” in the introductory language of subsection (1); and added subsections (3) and (4).

The 2013 amendment, by ch. 181, rewrote this section, adding subsections (4), (6) and (7) and the last sentence in subsection (5).

The 2015 amendment, by ch. 49, added paragraph (3)(c).

The 2017 amendment, by ch. 179, inserted the second sentence in subsection (6).

The 2019 amendment, by ch. 306, in paragraph (3), redesignated the existing paragraphs and added paragraph (c).

Compiler’s Notes.

The phrase “the effective date of this law” in subsection (6) refers to the effective date of S.L. 2013, Chapter 181, which was effective July 1, 2013.

§ 41-4011. Records and accounts — Annual statement. — (1) The trustee of a self-funded plan shall cause full and accurate records and accounts to be entered and maintained during all times of the existence of the trust covering all financial transactions and affairs of the trust fund, which records and accounts shall be subject to review by the director. Any audit of the plan or trust shall be completed independently of any other entity.

(2) Within ninety (90) days after close of a fiscal year of the plan, the trustee shall prepare an annual statement in writing summarizing the financial transactions of the trust fund for such fiscal year and the financial condition of the trust at the end of such year in accordance with the requirements of this chapter and with generally accepted accounting principles. The statement shall be in a form acceptable to the director and include such information as prescribed by the director. The financial information included therein shall be certified by the accountant who audited such information. The trustee shall promptly deliver a copy of the statement to each employer or postsecondary educational institution participating in the plan and keep a copy thereof on file in the business office from which the plan is operated. Such statement shall be available for review by any beneficiary at all reasonable times for a period of not less than three (3) years from the date of the statement. If the plan is managed by a third party administrator, such statement shall be available at the administrative offices of the employer or employers or postsecondary educational institution.

(3) The plan's annual statement shall be accompanied by the certified actuarial opinion described in [section 41-4010, Idaho Code](#). Such annual statement shall be prepared in accordance with actuarial standard of practice no. 28. The self-funded plan shall require that the qualified actuary retain the actuarial work papers until the department has filed an examination report of the plan covering the period of the actuarial opinion but no longer than seven (7) years from the date of such opinion.

(4) On or before expiration of such ninety (90) day period the trustee shall file an original of the annual statement and certified actuarial opinion

with the director. The actuarial opinion shall be filed in a form prescribed by the director. The trustee shall pay a filing fee as provided for by rule. The director may grant a thirty (30) day extension of the time for filing the annual statement.

(5) The trustee shall also file quarterly supplemental unaudited financial reports and other periodic supplemental unaudited financial reports in a form and at the times prescribed by the director.

(6) The director shall transmit and account for all fees received by him hereunder as provided in [section 41-406, Idaho Code](#).

(7) The annual and quarterly reports required under this section are public records and are available to the public, notwithstanding the exemptions from disclosure provided in chapter 1, title 74, Idaho Code.

History.

1974, ch. 248, § 11, p. 1624; am. 1984, ch. 23, § 13, p. 38; am. 2006, ch. 414, § 10, p. 1257; am. 2010, ch. 96, § 2, p. 182; am. 2013, ch. 181, § 11, p. 419; am. 2015, ch. 141, § 113, p. 379.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, substituted “ninety (90) days” for “sixty (60) days” in subsections (2) and (3); in subsection (2), substituted “this chapter” for “this act” in the first sentence; in subsection (3), substituted “trustee” for “trust fund” and added “The director may grant a thirty (30) day extension of the time for filing the annual statement” and added present subsection (4) and redesignated former subsection (4) as present subsection (5).

The 2010 amendment, by ch. 96, added subsection (6).

The 2013 amendment, by ch. 181, rewrote the section, adding subsection (3) and redesignating the subsequent subsections.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in subsection (7).

Compiler’s Notes.

For actuarial standard of practice no. 28, referred to in subsection (3), see [http://www. actuarialstandardsboard.org/asops/state-ments-actuarial-opinion-regarding-health- insurance-liabilities-assets/](http://www.actuarialstandardsboard.org/asops/state-ments-actuarial-opinion-regarding-health-insurance-liabilities-assets/).

§ 41-4012. Taxes. — (1) Each self-funded plan required to be registered under this chapter is subject to the tax as provided in this section. Each registered self-funded plan, and each formerly registered plan with respect to beneficiaries in this state while so registered, shall simultaneously with the filing of its annual statement with the director, pay to the director a tax computed at the rate of four cents (4¢) per month per beneficiary covered by the plan during the fiscal year of the annual statement with respect to all beneficiaries working or resident in this state. Any plans operating in Idaho without proper registration shall be subject to back taxes for all years the plan was in operation plus all other sanctions authorized by law.

(2) All excise, privilege, franchise, income, license and similar taxes, licenses and fees are hereby preempted from imposition upon self-funded plans and on the intangible property of their trust funds; and no county, city, municipality, district, school district, or other political subdivision or agency of Idaho shall levy upon such plans or trust funds any such tax, license or fee additional to those set forth in this chapter.

(3) The tax imposed on self-funded plans in subsection (1) of this section, together with the fees imposed on such plans as set forth in this chapter, shall be in lieu of any and all income taxes and other excise taxes, licenses and fees payable to the state of Idaho. No self-funded plan shall be required to file any tax returns or comply with any provisions governing such income taxes and other excise taxes, licenses and fees payable to the state of Idaho.

(4) The director shall promptly remit all such tax payments received by him pursuant to this section to the state treasurer for credit to the state general fund.

History.

1974, ch. 248, § 12, p. 1624; am. 1982, ch. 252, § 3, p. 643; am. 2006, ch. 414, § 11, p. 1257; am. 2013, ch. 181, § 12, p. 419.

STATUTORY NOTES

Cross References.

General fund, § 67-1205.

State treasurer, § 67-1201 et seq.

Amendments.

The 2006 amendment, by ch. 414, substituted “this chapter” for “this act” in subsections (2) and (3); and added “and no self-funded plan shall be required to file any tax returns or comply with any provisions governing such income taxes and other excise taxes, licenses and fees payable to the state of Idaho” at the end of subsection (3).

The 2013 amendment, by ch. 181, rewrote this section, adding the last sentence in subsection (1).

§ 41-4013. Examination of books, records and accounts. — (1) The books, records, accounts and affairs of a self-funded plan shall be subject to examination by the director, by qualified examiners duly authorized by him in writing, at such times or intervals as the director deems appropriate. The purposes of the examination shall be to determine compliance of the plan with applicable laws, the plan's financial condition, the adequacy of the plan's trust fund, the treatment accorded by the plan to its beneficiaries and any other factors deemed materially relevant by the director to the plan's management and operation.

(2) The trustee shall promptly make the books, records and accounts of the plan and trust fund available to the department's examiner in Idaho and otherwise facilitate the examination.

(3) The examiner shall conduct the examination expeditiously, prepare the report of the examination in writing, and deliver a copy thereof to the trustee and the director as soon as practicable. The trustee shall have no longer than four (4) weeks after receipt of the report within which to recommend to the director such corrections or changes therein as the trustee may deem appropriate. After making such corrections or changes, if any, as he deems appropriate, the director shall file the report in his office as a document open to public inspection, and deliver to the trustee a copy of the report, including any modifications made to the examiner's original report as submitted to the director.

(4) At the direction of the director, the costs of the examination shall be borne by the trust fund of the plan, and shall be paid by the trustee in accordance with [section 41-228, Idaho Code](#).

History.

1974, ch. 248, § 13, p. 1624; am. 2001, ch. 85, § 12, p. 211; am. 2006, ch. 414, § 12, p. 1257; am. 2013, ch. 181, § 13, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, inserted “promptly” and “in Idaho” in subsection (2) and substituted “four (4) weeks” for “two (2) weeks” in subsection (3).

The 2013 amendment, by ch. 181, rewrote this section, adding subsection (4).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4014. Trustees — Administrators — Bonding. — (1) Either an individual or a corporation or other legal entity may be a trustee of the trust fund. Any person acting as a trustee is a fiduciary acting on behalf of the beneficiaries of the plan and the trust fund in such capacity. An individual, firm, corporation or other legal entity may be an administrator of a plan.

(2) An employer participant in the plan shall be neither a trustee nor the administrator. A postsecondary educational institution as a plan sponsor of a self-funded plan shall be neither a trustee nor an administrator of such plan. However, this subsection shall not prohibit an individual who is otherwise an employee of such an employer or a postsecondary educational institution from being trustee or administrator.

(3) The trustee shall obtain a fidelity bond, or coverage deemed by the director to be equivalent to a fidelity bond, in the name of the self-funded plan, the purpose of which is to protect against acts of fraud and dishonesty by the plan's trustees, directors, officers and employees in connection with the trust fund or plan. Such bond shall be in an amount equal to the greater of ten percent (10%) of the contributions received by the plan or ten percent (10%) of the benefits paid during the preceding calendar year. If the plan was not in operation during the preceding calendar year, the bond shall be in an amount equal to ten percent (10%) of the contributions projected to be received by the plan during its first year of operation. The amount of any bond required under this section shall be not less than twenty-five thousand dollars (\$25,000) or more than five hundred thousand dollars (\$500,000).

(4) Any administrator that is retained by a self-funded plan must be licensed and bonded as an administrator pursuant to chapter 9, title 41, Idaho Code.

History.

1974, ch. 248, § 14, p. 1624; am. 2006, ch. 414, § 13, p. 1257; am. 2013, ch. 181, § 14, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, rewrote subsection (3), which formerly read: “The trustee shall cause all individuals handling receipts and disbursements for the trust fund to be bonded at all times under a fidelity bond issued by a surety insurer authorized to transact such insurance in this state. The bond shall be in favor of the trust fund and for such aggregate penalty amount, not less than twenty-five thousand dollars (\$25,000), as the director may deem reasonably advisable in relation to amount of funds to be so handled. The bond shall be noncancellable except upon not less than thirty (30) days advance notice in writing to the trustee and the director. The cost of the bond shall be borne by the trust fund.”

The 2013 amendment, by ch. 181, rewrote this section, adding subsection (4).

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4015. Prohibited pecuniary interests in plan management. — (1) No plan sponsor, trustee, administrator, or other person having responsibility for the management of a self-funded plan or the investment or other handling of trust funds shall:

(a) Receive directly or indirectly or have a pecuniary interest, either directly or indirectly, in any fee, commission, compensation, or emolument, other than salary or other similar compensation regularly fixed and authorized for services duly rendered to the plan, arising out of any transaction to which the trust fund is or may become a party.

(b) Receive compensation as a consultant to the plan while also acting as a trustee or administrator, or as an employee of either the trust fund or the plan.

(c) Have any direct or indirect material pecuniary interest in any loan or investment related to the trust fund.

(2) No consultant to the plan or trust fund shall directly or indirectly receive or have a pecuniary interest, either directly or indirectly, in any commission or other compensation arising out of any contract or transaction between the plan or trust fund and any insurer, health care service corporation, health maintenance organization or other provider of health care services or of drugs or other health care needs and supplies.

(3) The director may, after reasonable notice and the opportunity for a hearing, require removal of a trustee or prohibit the trustee from employing or retaining or continuing to employ or retain any person in the administration of the trust fund or plan, upon finding that continuation of the trustee or such employment or retention involves a conflict of interest or an interest with the potential to adversely affect plan beneficiaries.

History.

1974, ch. 248, § 15, p. 1624; am. 2006, ch. 414, § 14, p. 1257; am. 2013, ch. 181, § 15, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, inserted the second instance of “plan or” in subsection (2).

The 2013 amendment, by ch. 181, inserted “plan sponsor” near the beginning of subsection (1); substituted “have a pecuniary interest, either directly or indirectly” for “be pecuniary interested” in paragraph (1)(a) and in subsection (2); in subsection (2); inserted “the opportunity for a” preceding “hearing”; and made stylistic changes.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4016. Political contributions prohibited. — No trustee shall make or knowingly permit the making, directly or indirectly, of any political contribution by or from any self-funded plan trust fund.

History.

1974, ch. 248, § 16, p. 1624.

§ 41-4017. Recovery of depleted funds. — If after notice and the opportunity for a hearing the director finds that any self-funded plan trust fund has been depleted by reason of any wrongful or negligent act or omission of a trustee or any other person, he shall transmit a copy of his findings to the attorney general of this state, who may bring an action in the name of the people of this state, or intervene in any action brought by or on behalf of an employer or beneficiary, for the recovery of the amount of such depletion, for the benefit of the trust fund, and to impose any sanctions as authorized by law.

History.

1974, ch. 248, § 17, p. 1624; am. 2013, ch. 181, § 16, p. 419.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Amendments.

The 2013 amendment, by ch. 181, inserted “the opportunity for a” near the beginning and added “and to impose any sanctions as authorized by law” at the end.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4018. Termination of registration. — (1) The director shall terminate the registration of a self-funded plan upon written request of the trustee, or if he finds, after an inquiry or an examination, that the trust fund is insolvent. For the purposes of this chapter, “insolvent” means the plan is unable to pay its obligations when they are due or that its assets do not exceed its liabilities. As used in this chapter, “assets” means all investments held in the name of the trust as permitted by [section 41-4009, Idaho Code](#).

(2) The director may terminate the registration of a plan for violation of this chapter, or failure of the trustee to timely file with the director the annual statement or actuarial opinion and timely pay the tax required under sections 41-4011 and 41-4012, Idaho Code, or if he finds, after an inquiry or an examination of the trust fund and the plan or notice from the trustee:

- (a) That the plan no longer meets the qualifications required by sections 41-4004 and 41-4005, Idaho Code, and that such deficiency will not or cannot be remedied within a reasonable time;
- (b) That there is a pattern of benefits promised by the plan that are not being fairly and promptly paid;
- (c) That the cost of administering the plan is excessive in relation to the character and volume of service being rendered in the administration;
- (d) That the trust fund has been subject to fraudulent, incompetent or dishonest practices on the part of the trustee, administrator, consultant, any participating employer, any postsecondary educational institution, beneficiaries or others; or
- (e) That the trust fund does not meet the minimum surplus requirements under this chapter.

(3) The director shall terminate the plan’s registration by his written order provided to the trustee last of record with the department and to each employer or postsecondary educational institution last of record with the department. Such order shall state the grounds upon which it is based and its effective date. The order shall be subject to judicial review in the same manner as applies to official orders of the director in general.

History.

1974, ch. 248, § 18, p. 1624; am. 2006, ch. 414, § 15, p. 1257; am. 2013, ch. 181, § 17, p. 419.

STATUTORY NOTES**Amendments.**

The 2006 amendment, by ch. 414, added “For the purposes of this section, ‘insolvent’ means the plan is unable to pay its obligations when they are due or that its assets do not exceed its liabilities. As used in this section, ‘assets’ means all investments held in the name of the trust as permitted by [section 41-4009, Idaho Code](#)” at the end of subsection (1); and substituted “this chapter” for “this act” in subsection (2).

The 2013 amendment, by ch. 181, rewrote this section to the extent that a detailed comparison is impracticable.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4019. Liquidation of trust fund. — (1) Upon termination of registration of the plan, the trust fund of a self-funded plan shall be liquidated as soon as practicable.

(2) Liquidation of a solvent self-funded plan shall be conducted by its trustee under a plan of liquidation in writing filed with and approved by the director as fair and equitable to all persons having a pecuniary interest in the trust fund. Any balance remaining after payment or adequate provision for all claims and charges against the trust fund shall be disposed of in such manner as is provided for in the plan of liquidation. Unless the plan of liquidation provides that liability for all unpaid claims and obligations of the trust fund has been unconditionally assumed by other financially responsible person or persons and the third party contract has been submitted to the department for its review, the existence of surplus funds for such disposition shall not be determined prior to expiration of two (2) years after termination of the registration.

(3) The liquidation of an insolvent self-funded plan shall be carried out by the director in accordance with chapter 33, title 41, Idaho Code (rehabilitation and liquidation). For this purpose, the self-funded plan shall be deemed to be an insolvent domestic insurer and subject to all statutes and rules applicable to the same.

History.

1974, ch. 248, § 19, p. 1624; am. 2006, ch. 414, § 16, p. 1257; am. 2013, ch. 181, § 18, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, substituted “registration” for “administration” in subsection (1); inserted “of a solvent self-funded plan” in subsection (2); rewrote subsection (3), which formerly read: “The plan of liquidation of an insolvent trust fund, after such plan has been approved by the director, shall be binding upon all persons pecuniarily interested in the trust fund. Pending the effectuation of the plan of liquidation of an insolvent

trust fund the director may impose such prohibitions or restrictions upon disbursement or use of trust fund moneys as he deems advisable for the protection of all interested persons”; and deleted former subsection (4), which read: “If the trust fund is then insolvent and a plan of liquidation thereof satisfactory to the director as being fair and equitable is not filed with him within sixty (60) days after the effective date of termination of the plan’s registration, or if liquidation of a solvent trust fund is not being carried out in accordance with the plan of liquidation theretofore approved by him, the director shall liquidate the trust fund under the applicable provisions of chapter 33, title 41, Idaho Code (rehabilitation and liquidation), and for the purpose the trust fund shall be deemed to be an insolvent domestic insurer.”

The 2013 amendment, by ch. 181, rewrote this section to the extent that a detailed comparison is impracticable.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

The words in parentheses so appeared in the law as enacted.

§ 41-4020. Rules. — (1) The director may promulgate reasonable rules necessary for or as an aid to effectuation of any provision of this chapter. No such rule shall extend, modify, or conflict with any provision of this chapter and the reasonable implications thereof.

(2) Such rules, or any amendment thereof, shall be made by the director in accordance with chapter 52, title 67, Idaho Code.

History.

1974, ch. 248, § 20, p. 1624; am. 2006, ch. 414, § 17, p. 1257; am. 2013, ch. 181, § 19, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, deleted “and regulations” following “rules” in the section heading and throughout the section; in subsection (1), substituted “this chapter” for “this act” twice in the second sentence; rewrote subsection (2), which formerly read: “Such rules and regulations, or any amendment thereof, shall be made by the director only after a public hearing thereon of which the director has given written notice not less than thirty (30) days in advance to the trustee of each plan then registered with him. If reasonably possible the director shall include with the notice a copy of the proposed rules and regulations or amendment, or a condensed summary of material proposed provisions”.

The 2013 amendment, by ch. 181, substituted “promulgate reasonable rules” for “make reasonable rules.”

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

§ 41-4021. Other provisions applicable. — Chapter 2, title 41, Idaho Code, (the director of the department of insurance), chapter 9, title 41, Idaho Code, (insurance administrators), chapter 13, title 41, Idaho Code, (trade practices and frauds), chapter 56, title 41, Idaho Code, (prompt payment of claims), chapter 59, title 41, Idaho Code, (external review), **section 41-1845, Idaho Code**, (recreational-related activities), sections 41-2141 and 41-2216, Idaho Code, (coordination with social security benefits), and **section 41-2841, Idaho Code**, (borrowed surplus), to the extent applicable and not in conflict with the express provisions of this chapter, shall also apply with respect to self-funded plans, and for the purpose such plans shall be deemed to be “insurers.”

History.

1974, ch. 248, § 21, p. 1624; am. 1978, ch. 10, § 6, p. 19; am. 2006, ch. 414, § 18, p. 1257; am. 2013, ch. 181, § 20, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, inserted “and 41-2216, Idaho Code,” and “and **section 41-2841, Idaho Code**, (borrowed surplus)” and changed “this act” to “this chapter”.

The 2013 amendment, by ch. 181, inserted “chapter 9, title 41, Idaho Code, (insurance administrators)” and “chapter 56, title 41, Idaho Code, (prompt payment of claims), chapter 59, title 41, Idaho Code, (external review), **section 41-1845, Idaho Code**, (recreational-related activities).”

Compiler’s Notes.

The words in parentheses so appeared in the law as enacted.

§ 41-4022. Penalties. — (1) Any person who violates or causes or induces violation of any provision of this chapter, or any lawful rule of the director issued thereunder, shall be subject to an administrative penalty for each violation of not more than one thousand dollars (\$1,000) for an individual and not more than five thousand dollars (\$5,000) for any entity for each violation.

(2) Any person who makes a false statement or representation of a material fact, knowing it to be false, or who knowingly fails to disclose a material fact in any application, examination or statement relating to self-funded plans, trust accounts, administration of a plan or any matter materially related thereto, shall be subject to penalty as provided in subsection (4) of this section.

(3) Any person who makes a false entry in any book, record, statement, or report required by this chapter or any rule of the director promulgated thereunder, with intent to injure or defraud the trust fund or any beneficiary thereunder, or to deceive anyone authorized or entitled to examine the affairs of the plan, shall be subject to penalty as provided in subsection (4) of this section.

(4) For each such violation, act or omission referred to in subsections (2) and (3) of this section, unless greater penalty is provided therefor under any other applicable law, the offender shall upon conviction thereof be subject to a fine of not more than fifteen thousand dollars (\$15,000) and to imprisonment for not more than fifteen (15) years, or to both such fine and imprisonment.

(5) Further, the director may in his discretion:

- (a) Order the person to cease and desist from the violation of such provision;
- (b) Issue an order revoking or suspending the registration of the plan that engaged in such violation;
- (c) Bring an action in the fourth district court in and for Ada county or in such other court as the director deems appropriate to seek appropriate

injunctive relief and impose a civil penalty not to exceed five thousand dollars (\$5,000) for each violation.

History.

1974, ch. 248, § 22, p. 1624; am. 2006, ch. 414, § 19, p. 1257; am. 2013, ch. 181, § 21, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, rewrote subsection (1), which formerly read: “Any person who wilfully violates or causes or induces violation of any provision of this act or any lawful rule or regulation of the director issued thereunder, shall be subject to penalty as provided in subsection (4) of this section”; substituted “this chapter or by lawful rule” for “this act or by lawful rule or regulation” in subsections (2) and (3); and, in subsection (4), inserted “subsections (2) and (3) of”, substituted “fifteen thousand dollars (\$15,000)” for “one thousand dollars (\$1,000)” and “fifteen (15) years” for “one (1) year.”

The 2013 amendment, by ch. 181, in subsection (1) deleted “willfully” following “Any person who” at the beginning and added “for each violation” to the end; substituted “relating to self-funded plans, trust accounts, administration of a plan or any matter materially related thereto” for “required under this chapter or by lawful rule of the director thereunder” in subsection (2); added subsection (5); and made stylistic changes.

Compiler’s Notes.

In this section “commissioner” has been changed to “director” on authority of S.L. 1974, ch. 286, § 1 and S.L. 1974, ch. 11, § 3 (§ 41-203).

Section 23 of S.L. 1974, ch. 248 provided: “The provisions of this act are declared to be severable, and if any provision of this act in the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.”

Effective Dates.

Section 24 of S.L. 1974, ch. 248 provided the act take effect on and after July 1, 1974.

§ 41-4023. Coverage from moment of birth — Complications of pregnancy. — (1) Every self-funded plan issued pursuant to this chapter in this state, or providing coverage to any covered family residing within this state, shall contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn child or infant of any covered family, including a newborn child placed with the adoptive covered family within sixty (60) days of the adopted child's date of birth. Coverage under the self-funded plan for an adopted newborn child placed with the adoptive covered family more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accordance with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years of age as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive covered family, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive covered family signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection as to a child placed for adoption with a covered family continues in the same manner as it would with respect to a naturally born child of the covered family until the first to occur of the following events:

- (a) The date the child is removed permanently from that placement and the legal obligation terminates; or
- (b) The date the covered family rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

No such plan may be issued or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn or adopted children or infants of a covered family, which child or children are covered from and after the moment of birth that is inconsistent with the provisions of this section.

(2) Neither the plan trustee or employer or a postsecondary educational institution nor an insurer shall restrict coverage under a self-funded plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) No self-funded plan which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after January 1, 1977, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan. This subsection shall apply to all self-funded plans except any such plan made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this subsection, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All plans subject to this subsection and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(4) From and after January 1, 1998, no self-funded plan that provides maternity benefits shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

(5) Any new or renewing self-funded group disability plan or blanket disability plan delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-six (26) years shall be permitted to remain on the parent's or parents' plan. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' plan.

History.

I.C., § 41-4023, as added by 1976, ch. 113, § 5, p. 443; am. 1993, ch. 305, § 5, p. 1129; am. 1994, ch. 365, § 10, p. 1144; am. 2006, ch. 414, § 20, p. 1257; am. 2008, ch. 296, § 4, p. 828; am. 2009, ch. 125, § 6, p. 391; am. 2013, ch. 181, § 22, p. 419.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 414, added “Neither the plan trustee or employer nor” at the beginning of subsection (2); and added subsection (4).

The 2008 amendment, by ch. 296, added subsection (5).

The 2009 amendment, by ch. 125, rewrote the first sentence in subsection (5), which formerly read: “Any self-funded group disability plan or blanket disability plan delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-one (21) years or an unmarried child who is a full-time student under the age of twenty-five (25) years and who is financially dependent upon the parent shall be permitted to remain on the parent's or parents' contract.”

The 2013 amendment, by ch. 181, in subsection (1), inserted “pursuant to this chapter” near the beginning of the introductory paragraph and inserted “which child or children are” in the last paragraph; inserted “or a postsecondary educational institution” in subsection (2); and substituted

“twenty-six (26) years” for “twenty-five (25) years and who receives more than one-half (½) of his financial support from the parent” in subsection (5).

Federal References.

The Newborns’ and Mothers’ Health Protection Act of 1996, referred to in subsection (4) of this section, is compiled as 42 U.S.C.S., §§ 300gg-4, 300gg-11 to 300gg-13, 300gg-21 to 300gg-23, 300gg-41 to 300gg-44, and 300gg-61 to 300gg-63.

Effective Dates.

Section 6 of S.L. 1976, ch. 113 provided that the act should take effect on and after January 1, 1977.

§ 41-4024. Services provided by governmental entities. — (1) From and after July 1, 1990, no self-funded plan shall be issued in Idaho which excludes from coverage services rendered the subscriber while a resident in an Idaho state institution, provided the services to the subscriber would be covered by the contract if rendered to him outside an Idaho state institution.

(2) From and after July 1, 1990, no self-funded plan may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a contract which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of coverage under a self-funded plan.

History.

I.C., § 41-4024, as added by 1990, ch. 300, § 5, p. 827.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

§ 41-4025. Mammography coverage. — (1) From and after July 1, 1992, all self-funded plans which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:

- (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
- (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
- (c) A mammogram every year for any woman who is fifty (50) years of age or older.
- (d) A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

History.

I.C., § 41-4025, as added by 1992, ch. 132, § 5, p. 413; am. 1993, ch. 113, § 5, p. 288.

STATUTORY NOTES

Effective Dates.

Section 6 of S.L. 1993, ch. 113 provided that the act shall be in full force and effect on July 1, 1993.

**§ 41-4026. Health insurance coverage for dependent children.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-4026, as added by 1994, ch. 365, § 11, p. 1144; am. 1998, ch. 292, § 26, p. 928, was repealed by S.L. 2003, ch. 304, § 1, effective July 1, 2003.

Chapter 41

JOINT PUBLIC AGENCY SELF-FUNDED HEALTH CARE PLANS

Sec.

41-4101. Declaration of purpose.

41-4102. Definitions.

41-4103. Registration required — Exemptions — Not subject to insurance code.

41-4104. Qualifications for registration.

41-4105. Application for registration.

41-4106. Grant or denial of application.

41-4107. Trust fund — Powers.

41-4108. Trust fund liability.

41-4109. Investment of trust fund.

41-4110. Reserves.

41-4111. Records and accounts — Annual statement.

41-4112. Taxes — Exemption.

41-4113. Examination of books, records and accounts.

41-4114. Board of trustees — Administrators.

41-4115. Prohibited pecuniary interests in plan management.

41-4116. Political contributions prohibited.

41-4117. Recovery of depleted funds.

41-4118. Termination of registration.

41-4119. Liquidation of trust fund.

41-4120. Rules.

41-4121. Other provisions applicable.

41-4122. Penalties.

41-4123. Coverage from moment of birth — Complications of pregnancy.

41-4124. Services provided by governmental entities.

41-4125. Mammography coverage.

§ 41-4101. Declaration of purpose. — It is the purpose of this chapter to recognize and provide reasonable public supervision of self-funded plans established by public agencies pursuant to a joint powers agreement in accordance with chapter 23, title 67, Idaho Code, for provision of health care service benefits to employees of public agencies in connection with or as an alternative to insurance and other prepayment plans.

History.

I.C., § 41-4101, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former Chapter 41, entitled Medical Malpractice Insurance, consisting of §§ 41-4101 — 41-4116, which comprised 1975, ch. 163, §§ 1, 2, 4-14, p. 427; 1976, ch. 225, §§ 1, 2, 4-7, p. 803; 1977, ch. 142, § 12, p. 303; 1977, ch. 198, § 1, p. 534; 1979, ch. 98, §§ 1-3, p. 236, was repealed by S.L. 1988, ch. 172, § 1.

§ 41-4102. Definitions. — As used in this chapter:

(1) “Administrator” means a person, other than a board member, employed by the board to administer a joint public agency self-funded plan.

(2) “Beneficiary” means any individual entitled, under the joint public agency self-funded plan, to payment by the trust fund of any part of all of the cost of any health care service rendered to him.

(3) “Board of trustees” or “board” is the board of trustees of the trust fund.

(4) “Contribution” means the amount paid or payable by the employer or employee into the trust fund.

(5) “Director” means the director of the department of insurance of this state.

(6) “Joint powers agreement” means an agreement entered into between public agencies pursuant to chapter 23, title 67, Idaho Code.

(7) “Joint public agency self-funded plan” or “self-funded plan” or “plan” means any public agency plan established by a joint powers agreement and under which payment for any disability benefits not otherwise provided for under title 72, Idaho Code (worker’s compensation and related laws — industrial commission), medical, surgical, hospital, and other services for prevention, diagnosis, or treatment of any disease, injury, or bodily condition of an employee is, or is to be, regularly provided for or promised from funds created or maintained in whole or in part by contributions or payments thereto by a public agency employer, or by a public agency employer and the employees of the public agency, and not otherwise covered by insurance or contract with a health care service corporation, health maintenance organization, or similar other third party prepayment plan.

(8) “Person” means any individual, corporation, association, firm, syndicate, organization or other entity.

(9) “Public agency” means any city, county or political subdivision of this state, including, but not limited to: counties; school districts; highway

districts; port authorities; instrumentalities of counties, county hospitals, cities or any political subdivision created under the laws of the state of Idaho; and the state of Idaho and any agency of the state government. “Public agency” also means any group of more than one (1) of the above public agencies acting together pursuant to a joint powers agreement in accordance with chapter 23, title 67, Idaho Code.

(10) “Surplus” means the excess of the assets of a self-funded plan minus the liabilities of the plan, provided the liabilities of a self-funded plan shall include the claims liability of the plan.

(11) “Trust fund” means a fund established under a joint public agency self-funded plan for receipt of contributions of employers and employees and payment of or with respect to health care service costs of beneficiaries.

History.

I.C., § 41-4102, as added by 2006, ch. 415, § 1, p. 1271; am. 2018, ch. 61, § 1, p. 151.

STATUTORY NOTES

Prior Laws.

Former § 41-4102 was repealed. See Prior Laws, § 41-4101.

Amendments.

The 2018 amendment, by ch. 61, inserted present subsection (10) and redesignated former subsection (10) as subsection (11).

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-4103. Registration required — Exemptions — Not subject to insurance code. — (1) No joint public agency self-funded plan shall operate in this state except while registered with the director as hereinafter provided. Joint public agency self-funded plans already in operation as of July 1, 2006, shall so register within ninety (90) days of the effective date of this act.

(2) No registration shall be required of: (a) Any plan established and maintained for the purpose of complying with any worker's compensation law or unemployment compensation disability insurance law; or (b) Any plan that is primarily for the purpose of providing first aid care and treatment, at a dispensary of an employer, for injury or sickness of employees while engaged in their employment.

(3) Plans while so registered shall not be deemed to be engaged in the business of insurance and shall not be subject to provisions of the Idaho insurance code except as expressly provided in this chapter.

(4) The plan shall provide to each employer participant and to each prospective employer participant a written notice stating that the plan is not insurance and does not participate in the state guaranty association.

History.

I.C., § 41-4103, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4103 was repealed. See Prior Laws, § 41-4101.

Compiler's Notes.

The phrase "the effective date of this act" in subsection (1) refers to the effective date of S.L. 2006, Chapter 415, which was effective July 1, 2006.

§ 41-4104. Qualifications for registration. — No joint public agency self-funded plan shall register, and the director shall not register a joint public agency self-funded plan, which is not qualified as provided in this section.

(1) The joint powers agreement must require all contributions to be paid in advance and to be deposited in and disbursed from a trust fund duly created and existing under an adequate written irrevocable trust agreement between the employer or employers and the board.

(2) The plan must:

(a) Have, or provide for, a board of trustees in accordance with this chapter for the administration of the plan;

(b) Require that all members of the joint powers agreement comply with the provisions of the joint powers agreement;

(c) Provide that the administrator or board on behalf of the plan, as the case may be, shall furnish to each employee-beneficiary of the plan a written statement or schedule adequately and clearly stating all benefits currently allowable under the plan, together with all applicable restrictions, limitations, and exclusions, and the procedure for filing a claim for benefits; and

(d) Otherwise be in compliance with the provisions of this chapter.

(3) The allocated trust fund must be actuarially sound; that is, assets and income of the fund must be adequate under reasonable estimates for payment of all benefits promised to beneficiaries by the plan. In determining actuarial soundness the director shall also give due consideration to:

(a) Applicable stop-loss insurance provided or to be provided the plan by an insurer duly authorized to transact disability insurance in this state;

(b) Contracts with health care service corporations or health maintenance organizations authorized to conduct such operations in this state and covering certain of the promised benefits;

(c) Other applicable insurance or guarantys; and

(d) The nature of the participating entities and other plan factors or provisions for prevention or reduction of adverse selection against the plan by those otherwise eligible to become beneficiaries.

(4) The plan shall maintain aggregate stop-loss coverage and specific stop-loss coverage provided by an insurance company authorized to transact insurance in this state in accordance with the annual actuarial opinion of the plan, unless waived pursuant to [section 41-4110\(3\), Idaho Code](#).

History.

[I.C., § 41-4104](#), as added by 2006, ch. 415, § 1, p. 1271; am. 2018, ch. 61, § 2, p. 151.

STATUTORY NOTES

Prior Laws.

Former § 41-4104 was repealed. See Prior Laws, § 41-4101.

Amendments.

The 2018 amendment, by ch. 61, added “unless waived pursuant to [section 41-4110\(3\), Idaho Code](#)” at the end of subsection (4).

§ 41-4105. Application for registration. — (1) Application for registration of a joint public agency self-funded plan for public agencies shall be made to the director, on forms furnished and designed by him. The application shall be signed and verified by at least two (2) of the board members.

(2) The application shall be accompanied by:

(a) A copy of the joint powers agreement under which the joint public agency self-funded plan will exist and operate;

(b) A copy of the proposed written statement of benefits referred to in [section 41-4104\(2\), Idaho Code](#);

(c) A financial statement of the trust fund, if already in existence and operating on July 1, 2006. The statement shall be certified by an independent certified public accountant according to generally accepted accounting principles;

(d) If not already in existence, a written statement of reasonably projected income and disbursements of the trust fund for the twelve (12) month period commencing with date of application and showing also the amount projected as of the end of such period for claims incurred and not paid and incurred and not reported as certified by an actuary having experience in establishing rates for a self-funded plan and the health services being provided, and who is also a fellow of the society of actuaries, a member of the American academy of actuaries, or an enrolled actuary under the employment retirement income security act of 1974;

(e) If not already in existence, a copy of a business plan;

(f) A copy of an actuarial study determining adequate rates for the plan. The rates shall not be less than the sum of projected incurred claims for the year plus costs of operation plus a reasonable portion of any prior year deficiency less any excess surplus; and

(g) Such other relevant documentation and information as the director may reasonably require considering that these entities are public agency plans and not private insurance companies.

(3) At the time of filing the application the applicant shall pay to the director a nonrefundable filing fee as provided for by rule.

(4) The director shall transmit and account for all fees received by him hereunder as provided in [section 41-406, Idaho Code](#).

History.

[I.C., § 41-4105](#), as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4105 was repealed. See Prior Laws, § 41-4101.

Federal References.

“Enrolled actuary,” referred to at the end of paragraph (2)(d), is defined for the employee retirement income security act of 1974 in [29 USCS § 1023](#).

Compiler’s Notes.

For society of actuaries, referred to in paragraph (2)(d), see <http://www.soa.org>.

For American academy of actuaries, referred to in paragraph (2)(d), see <http://www.actuary.org>.

§ 41-4106. Grant or denial of application. — The director shall act upon an application for registration of a joint public agency self-funded plan with all reasonable promptness. He may make a reasonable investigation of the proposal from the public agency. If the director finds that the application is complete and that the plan meets the qualifications stated in [section 41-4104, Idaho Code](#), he shall issue and deliver a certificate of registration in appropriate form to the applicant; otherwise, the director shall refuse to register the plan and shall give written notice of such refusal to the applicant, stating the reasons therefor.

History.

[I.C., § 41-4106](#), as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4106 was repealed. See Prior Laws, § 41-4101.

§ 41-4107. Trust fund — Powers. — In addition to the inherent applicable powers of its public agency members and those of a joint powers entity, the trust fund of a joint public agency self-funded plan shall have power:

(1) To have and use an appropriate descriptive name; (2) To sue and be sued in its own name; (3) To contract in its own name. All such contracts in writing shall be signed by the chairman of the board or his or her designee; (4) To borrow money and give security therefor; and (5) To engage exclusively in transactions authorized or required by this chapter, or reasonably incidental thereto.

History.

I.C., § 41-4107, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4107 was repealed. See Prior Laws § 41-4101.

§ 41-4108. Trust fund liability. — (1) The trust fund of a joint public agency self-funded plan shall be legally liable for payment of all applicable benefits stated in the statement or schedule of benefits in effect at the time a claim thereunder arises and subject to the terms of the joint powers agreement.

(2) Funds in the trust fund are fiduciary funds, and are not liable for any obligation of any employer participant in the plan, nor subject to garnishment or levy for the obligation of the beneficiary. This subsection (2) shall not be deemed to prohibit levy upon the trust fund by any provider thereof, or its assignee, for health care services rendered a beneficiary if the trust fund has theretofore agreed in writing to pay for the same direct to such provider.

History.

I.C., § 41-4108, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4108 was repealed. See Prior Laws, § 41-4101.

§ 41-4109. Investment of trust fund. — (1) The board may invest reserves and other funds available for the purpose in the trust fund of a joint public agency self-funded plan in the following kinds of investments only:

(a) General obligations of the United States government, or of any state, district, commonwealth or territory of the United States, or of any municipality, county, or other political subdivision or agency thereof.

(b) Obligations, the payment of principal and interest of which is guaranteed by any such government or agency.

(c) Corporate bonds and similar obligations meeting the requirements specified for investment of funds of insurers under [section 41-711, Idaho Code](#).

(d) Collateral loans, payment of principal and interest of which is adequately secured by securities in which the trust fund could lawfully invest directly.

(e) Deposits, savings accounts, and share accounts in established banks and savings and loan associations located in the United States.

(2) In addition to investments excluded under subsection (1) of this section, the board is expressly prohibited from investing trust fund moneys in: (a) Any loan to or security of any employer participating in the plan, or to or of any officer, director, subsidiary or affiliate of any such employer.

(b) The security of any person in which a member of the board, administrator, or any consultant of the plan has a direct or indirect material pecuniary interest.

(c) Real estate or loans thereon.

(d) Any personal loan, other than a collateral loan referred to in subsection (1)(d) of this section, but subject to paragraphs (a) and (b) of this subsection (2).

(3) All such investments shall be made and held in the name of the trust fund, and the interest and yield thereon shall inure to the account of the trust fund.

(4) No investment shall be made unless authorized in writing by the board and so shown in the records of the trust fund.

(5) Any person who authorizes any investment of trust fund moneys in violation of this section shall, in addition to other penalty therefor, be liable for all loss suffered by the trust fund on account of the investment.

(6) No investment made in violation of this section shall constitute an “asset” in any determination of the financial condition of the trust fund.

History.

I.C., § 41-4109, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4109 was repealed. See Prior Laws, § 41-4101.

§ 41-4110. Reserves. — (1) A joint public agency self-funded plan shall establish and maintain in its trust fund the following reserves:

(a) A reserve in an amount as certified by a member of the American academy of actuaries as being necessary for payment of claims against the trust fund for benefits, including both claims reported and not yet paid and claims incurred but not yet reported. Any joint public agency self-funded plan in existence as of July 1, 2006, shall also have three (3) years from the effective date of this act to fund the applicable reserves.

(b) If under the plan periodic contributions of either the employer or employees to the trust fund are payable less frequently than monthly, there shall be a reserve for unearned contributions as computed pro rata on the basis of the unexpired portion of the period for which the contribution has been paid.

(2) In any determination of the financial condition of the trust fund, the claims reserve and reserve for unearned contributions shall constitute liabilities.

(3) Upon request of a plan, the director shall have the authority to annually waive the requirement that the plan maintain aggregate stop-loss coverage if:

(a) The joint public agency self-funded plan established by a joint powers agreement is governed by a board of trustees and is operating as a public agency;

(b) Enrollment under the plan averages a minimum of one thousand (1,000) covered persons in each of the preceding twelve (12) months;

(c) The plan establishes and maintains, in its trust fund, reserves as set forth in subsection (1)(a) of this section; and

(d) The plan establishes and maintains, in its trust fund, surplus of at least the amount certified annually by a member of the American academy of actuaries as sufficient without aggregate stop-loss coverage, but no less than three (3) months of contributions.

History.

I.C., § 41-4110, as added by 2006, ch. 415, § 1, p. 1271; am. 2018, ch. 61, § 3, p. 151.

STATUTORY NOTES

Prior Laws.

Former § 41-4110 was repealed. See Prior Laws, § 41-4101.

Amendments.

The 2018 amendment, by ch. 61, added subsection (3).

Compiler's Notes.

For American academy of actuaries, referred to in paragraph (1)(a), see <http://www.actuary.org>.

The phrase “the effective date of this act” in paragraph (1)(a) refers to the effective date of S.L. 2006, Chapter 415, which was effective July 1, 2006.

§ 41-4111. Records and accounts — Annual statement. — (1) The board of a joint public agency self-funded plan shall cause full and accurate records and accounts to be entered and maintained covering all financial transactions and affairs of the trust fund.

(2) Within ninety (90) days after the close of a fiscal year of the plan, the board shall make an annual statement in writing summarizing the financial transactions of the trust fund for such fiscal year and its financial condition at the end of such year in accordance with this chapter and generally accepted and applicable accounting principles. The statement shall be in the form as prescribed by the director and the financial information therein shall be certified by an independent public accountant by whom such information was prepared. The board shall keep a copy thereof on file in the business office of the plan where it shall be available at all reasonable times for a period of not less than three (3) years for review by any beneficiary and shall deliver a copy of a financial summary to each participating employer.

(3) On or before expiration of such ninety (90) day period the board shall cause an original of the annual statement to be filed with the director. The joint public agency self-funded plan shall not be subject to any filing fees provided for by rule. The director may grant a thirty (30) day extension of the time for filing the annual statement.

(4) The board shall also file quarterly supplemental financial reports in a form and at the times prescribed by the director.

(5) The annual and quarterly reports required under this section are public records and are available to the public, notwithstanding the exemptions from disclosure provided in chapter 1, title 74, Idaho Code.

History.

I.C., § 41-4111, as added by 2006, ch. 415, § 1, p. 1271; am. 2010, ch. 96, § 3, p. 182; am. 2015, ch. 141, § 114, p. 379.

STATUTORY NOTES

Prior Laws.

Former § 41-4111 was repealed. See Prior Laws, § 41-4101.

Amendments.

The 2010 amendment, by ch. 96, in subsection (5), substituted “are public records” for “shall be public records,” and added “and are available to the public, notwithstanding the exemptions from disclosure provided in chapter 3, title 9, Idaho Code.”

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in subsection (5).

Idaho Code § 41-4112

§ 41-4112. Taxes — Exemption. — Any plan established under this chapter is not subject to any state tax, including a premium or maintenance tax.

History.

I.C., § 41-4112, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4112 was repealed. See Prior Laws, § 41-4101.

§ 41-4113. Examination of books, records and accounts. — (1) The books, records, accounts and affairs of a joint public agency self-funded plan shall be subject to examination by the director, by competent examiners duly authorized by him in writing, at such times or intervals as the director deems advisable. The purposes of the examination shall be to determine compliance of the plan with applicable laws, financial condition and actuarial adequacy of its trust fund, treatment accorded beneficiaries, and as to other factors materially related to the plan's management and operation.

(2) The board shall promptly make the books, records and accounts of the plan and trust fund available in Idaho to the examiner and otherwise facilitate the examination.

(3) The examiner shall conduct the examination expeditiously, make his report of the examination in writing, and deliver a copy thereof to the board and to the director. The board shall have four (4) weeks after receipt of the report within which to recommend to the director such corrections or changes therein as the board may deem appropriate. After making such corrections or changes, if any, as he deems proper, the director shall file the report in his office as a document open to public inspection, and deliver to the board a copy of the report as so corrected or changed.

(4) Since a joint public agency self-funded plan is funded by local tax moneys, the costs of the examination shall not be borne by the plan or trust fund of the plan.

History.

I.C., § 41-4113, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4113 was repealed. See Prior Laws, § 41-4101.

§ 41-4114. Board of trustees — Administrators. — (1) The trust shall be governed and managed by a board of trustees. This board shall consist of members elected by the governing boards of the member public agencies. The composition and membership of the board shall be established in the joint powers agreement between the members. The process and procedure for conducting the election and determining the members shall be set forth in the joint powers agreement establishing the plan, except that the election must be conducted, completed and results certified by December 31 of each year in which an election for members is conducted. Boards of joint public agency self-funded plans existing as of July 1, 2006, shall be deemed to be in compliance with the establishment requirements of this chapter but shall conduct future elections in accordance with the requirements of this chapter.

(2) An individual, firm or corporation may be an administrator of a plan.

(3) The board shall cause all individuals handling receipts and disbursements for the trust fund to be covered under a dishonesty insurance policy or surety bond in an amount not less than ten percent (10%) of the annual contributions to the plan or as the director may deem reasonably advisable, issued by an insurer authorized to transact such insurance in this state. This policy shall only be canceled upon giving no less than thirty (30) days' notice to the board and to the director. The cost of the insurance shall be borne by the trust fund. The amount of any policy or bond required under this section shall be not less than twenty-five thousand dollars (\$25,000) or more than five hundred thousand dollars (\$500,000).

History.

I.C., § 41-4114, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4114 was repealed. See Prior Laws, § 41-4101.

§ 41-4115. Prohibited pecuniary interests in plan management. — No board member, administrator or other person having responsibility for the management of a joint public agency self-funded plan or the investment or other handling of plan funds shall:

(1) Receive directly or indirectly or be pecuniarily interested in any fee, commission, compensation, or emolument, other than salary or other compensation regularly fixed and allowed for services regularly rendered to the plan, arising out of any transaction to which the trust fund is or is to be a party; (2) Receive compensation as a consultant to the plan while also acting as a board member or administrator, or as an employee of either; or (3) Have any direct or indirect material pecuniary interest in any loan or investment of the trust fund.

History.

I.C., § 41-4115, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4115 was repealed. See Prior Laws, § 41-4101.

§ 41-4116. Political contributions prohibited. — No board shall make or knowingly permit the making, directly or indirectly, of any political contribution by or from any joint public agency self-funded plan trust fund.

History.

I.C., § 41-4116, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Prior Laws.

Former § 41-4116 was repealed. See Prior Laws, § 41-4101.

§ 41-4117. Recovery of depleted funds. — If after notice and hearing the director finds that any joint public agency self-funded plan trust fund has been depleted by reason of any wrongful or grossly negligent act or omission of a board member or any other person, he shall transmit a copy of his findings to the attorney general of this state, who may bring an action in the name of the people of this state, or intervene in any action brought by or on behalf of an employer or beneficiary, for the recovery of the amount of such depletion, for the benefit of the trust fund.

History.

I.C., § 41-4117, as added by 2006, ch. 415, § 1, p. 1271.

§ 41-4118. Termination of registration. — (1) The director may terminate the registration of a joint public agency self-funded plan upon written request of the board, or if he finds, after an examination, that the trust fund is insolvent.

(2) The director may terminate the registration of a plan for violation of this chapter, or failure of the board to file the annual statement with the director within the time required under [section 41-4111, Idaho Code](#), or if he finds, after an examination of the trust fund or the plan: (a) That the plan no longer meets the qualifications required by sections 41-4101 and 41-4110, Idaho Code, and that the deficiency will not or cannot be remedied within a reasonable time; (b) That as a matter of frequent practice the benefits promised by the plan are not being fairly and promptly paid;

(c) That the cost of administering the plan is excessive in relation to the character and volume of service being rendered in the administration; or

(d) That the trust fund has been subject to fraudulent or dishonest practices on the part of the board, administrator, consultant, any participating employer, or beneficiaries.

(3) The director shall so terminate the registration by his written order given to the board and to each employer last of record a participant in the plan. The order shall state the grounds upon which it is made and its effective date. The order shall be subject to judicial review in the same manner as applies to official orders of the director in general.

History.

[I.C., § 41-4118](#), as added by 2006, ch. 415, § 1, p. 1271.

§ 41-4119. Liquidation of trust fund. — (1) Upon termination of registration the trust fund of a joint public agency self-funded plan shall be liquidated.

(2) Liquidation of a solvent joint public agency self-funded plan shall be conducted by its trustee under a plan of liquidation in writing filed with the director, found by the director to be fair and equitable to all persons having a pecuniary interest in the trust fund, and approved by him. Any balance remaining after payment or adequate provision for all claims and charges against the trust fund shall be disposed of in such manner as is provided for in the plan of liquidation. Unless under the plan of liquidation liability for all unpaid claims and obligations of the trust fund has been assumed by other financially responsible person or persons, the existence of surplus funds for such disposition shall not be determined prior to expiration of two (2) years after termination of the registration.

(3) The liquidation of an insolvent joint public agency self-funded plan shall be carried out by the director in accordance with chapter 33, title 41, Idaho Code (supervision, rehabilitation and liquidation), and for this purpose the joint public agency self-funded plan shall be deemed to be an insolvent domestic insurer.

History.

I.C., § 41-4119, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-4120. Rules. — (1) The director may make reasonable rules necessary for or as an aid to effectuation of any provision of this chapter. No such rule shall extend, modify, or conflict with any provision of this chapter and the reasonable implications thereof nor any of the administrative, statutory or constitutional rights and responsibilities of a public agency.

(2) Such rules, or any amendment thereof, shall be made by the director in accordance with chapter 52, title 67, Idaho Code.

History.

I.C., § 41-4120, as added by 2006, ch. 415, § 1, p. 1271.

§ 41-4121. Other provisions applicable. — Chapter 2, title 41, Idaho Code (the director of the department of insurance), chapter 13, title 41, Idaho Code (trade practices and frauds), and sections 41-2141(1) and 41-2216(1), Idaho Code (coordination of benefits, except to the extent the rules pertain to medicare coverage), to the extent applicable and not in conflict with the express provisions of this chapter, shall also apply with respect to joint public agency self-funded plans, and for the purpose such plans shall be deemed to be “insurers.”

History.

I.C., § 41-4121, as added by 2006, ch. 415, § 1, p. 1271.

STATUTORY NOTES

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-4122. Penalties. — (1) Any person who violates or causes or induces violation of any provision of this chapter or any lawful rule of the director issued hereunder, shall be subject to an administrative penalty for each violation of not more than one thousand dollars (\$1,000) for an individual and not more than five thousand dollars (\$5,000) for any entity.

(2) Any person who makes a false statement or representation of a material fact, knowing it to be false, or who knowingly fails to disclose a material fact in any application, examination, or statement required under this chapter or by lawful rule of the director hereunder, shall be subject to penalty as provided in subsection (4) of this section.

(3) Any person who makes a false entry in any book, record, statement, or report required by this chapter or lawful rule of the director thereunder to be kept by him for any joint public agency self-funded plan, with intent to injure or defraud the fund or any beneficiary thereunder, or to deceive any person authorized or entitled to examine the affairs of the plan, shall be subject to penalty as provided in subsection (4) of this section.

(4) For each such violation, act or omission referred to in subsections (2) and (3) of this section, unless greater penalty is provided therefor under any other applicable law, the offender shall upon conviction thereof be subject to a fine of not more than fifteen thousand dollars (\$15,000) and to imprisonment for not more than fifteen (15) years, or to both such fine and imprisonment.

History.

I.C., § 41-4122, as added by 2006, ch. 415, § 1, p. 1271.

§ 41-4123. Coverage from moment of birth — Complications of pregnancy. — (1) Every joint public agency self-funded plan issued in this state or providing coverage to any covered family residing within this state, shall contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn child or infant of any covered family, including a newborn child placed with the adoptive covered family within sixty (60) days of the adopted child's date of birth. Coverage under the joint public agency self-funded plan for an adopted newborn child placed with the adoptive covered family more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accordance with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years of age as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive covered family, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive covered family signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a covered family continues in the same manner as it would with respect to a naturally born child of the covered family until the first to occur of the following events:

- (a) The date the child is removed permanently from that placement and the legal obligation terminates; or
- (b) The date the covered family rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

No such plan may be issued or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn or adopted children or infants of a covered family

covered from and after the moment of birth that is inconsistent with the provisions of this section.

(2) An insurer shall not restrict coverage under a joint public agency self-funded plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(3) No joint public agency self-funded plan which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan.

For purposes of this subsection (3), involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All plans subject to this subsection (3) and issued, amended, delivered, or renewed in this state shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

History.

I.C., § 41-4123, as added by 2006, ch. 415, § 1, p. 1271.

§ 41-4124. Services provided by governmental entities. — (1) From and after July 1, 2006, no joint public agency self-funded plan shall be issued in Idaho which excludes from coverage services rendered the subscriber while a resident in an Idaho state institution, provided the services to the subscriber would be covered by the contract if rendered to him outside an Idaho state institution.

(2) From and after July 1, 2006, no joint public agency self-funded plan may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a contract which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of coverage under a joint public agency self-funded plan.

(3) Any new or renewing joint public agency self-funded plan delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half ($\frac{1}{2}$) of his financial support from the parent shall be permitted to remain on the parent's or parents' plan. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' plan.

History.

I.C., § 41-4124, as added by 2006, ch. 415, § 1, p. 1271; am. 2008, ch. 296, § 5, p. 830; am. 2009, ch. 125, § 7, p. 391.

STATUTORY NOTES

Amendments.

The 2008 amendment, by ch. 296, added subsection (3).

The 2009 amendment, by ch. 125, rewrote the first sentence in subsection (3), which formerly read: “Any joint public agency self-funded plan delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-one (21) years or an unmarried child who is a full-time student under the age of twenty-five (25) years and who is financially dependent upon the parent shall be permitted to remain on the parent’s or parents’ contract.”

§ 41-4125. Mammography coverage. — (1) From and after July 1, 2006, all joint public agency self-funded plans which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or equivalent examination coverage. Such coverage shall include at least the following benefits:

- (a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
- (b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
- (c) A mammogram every year for any woman who is fifty (50) years of age or older.
- (d) A mammogram for any woman desiring a mammogram for medical cause. Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

History.

I.C., § 41-4125, as added by 2006, ch. 415, § 1, p. 1271.

Chapter 42

INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES

Sec.

41-4201. Purpose.

41-4202. Definitions.

41-4203. Standards for policy provisions.

41-4204. Minimum standards for benefits.

41-4205. Outline of coverage.

41-4206. Pre-existing conditions. [Repealed.]

41-4207. Administrative procedure.

§ 41-4201. Purpose. — The purpose of this act shall be to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies, group supplemental disability insurance policies, nongroup subscriber contracts of nonprofit hospitals, medical and dental service associations, and nongroup subscriber contracts of managed care organizations to facilitate public understanding and comparison, to eliminate provisions contained in individual disability insurance policies, group supplemental disability insurance policies, nongroup subscriber contracts of nonprofit hospital, medical and dental service associations, and nongroup subscriber contracts of managed care organizations which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of disability coverages.

History.

1975, ch. 205, § 1, p. 569; am. 2009, ch. 66, § 1, p. 187.

STATUTORY NOTES

Amendments.

The 2009 amendment, by ch. 66, twice inserted “group supplemental disability insurance policies” and twice substituted “managed care organizations” for “health maintenance organizations.”

Compiler’s Notes.

The term “this act” near the beginning of the section refers to S.L. 1975, Chapter 205, compiled as §§ 41-4201 to 41-4205 and 41-4207.

§ 41-4202. Definitions. — (1) “Form” includes but is not limited to policies, contracts, certificates, riders, endorsements, and applications as provided in sections 41-1812, 41-3419 and 41-3915, Idaho Code.

(2) “Disability Insurance” means insurance written under chapter 21, title 41, Idaho Code, supplemental disability insurance written under chapter 22, title 41, Idaho Code, coverages written under chapter 34, title 41, Idaho Code, and coverages written under chapter 39, title 41, Idaho Code. For purposes of this act, nonprofit hospital, medical and dental service associations, and managed care organizations shall be deemed to be engaged in the business of insurance.

(3) “Policy” means the entire contract between the insurer and the insured, including the policy, certificates, riders, endorsements, and the application, if attached, and also includes nongroup subscriber contracts issued by nonprofit hospital, medical and dental service associations, and nongroup subscriber contracts issued by managed care organizations.

History.

1975, ch. 205, § 2, p. 569; am. 2009, ch. 66, § 2, p. 187.

STATUTORY NOTES

Amendments.

The 2009 amendment, by ch. 66, in subsection (1), inserted the last section reference; in subsections (1) and (3), inserted “certificates”; in subsection (2), inserted “supplemental disability insurance written under chapter 22, title 41, Idaho Code”; and in subsections (2) and (3), substituted “managed care organizations” for “health maintenance organizations.”

Compiler’s Notes.

The term “this act” in subsection (2) refers to S.L. 1975, Chapter 205, compiled as §§ 41-4201 to 41-4205 and 41-4207.

§ 41-4203. Standards for policy provisions. — (1) The director shall issue rules, subject to chapter 52, title 67, Idaho Code, to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of disability insurance, group supplemental policies of disability insurance, nongroup subscriber contracts of nonprofit hospital, medical and dental service associations and nongroup subscriber contracts of managed care organizations which shall be in addition to and in accordance with applicable laws of this state, which may cover but shall not be limited to:

(a) Terms or renewability; (b) Initial and subsequent conditions of eligibility; (c) Nonduplication of coverage provisions; (d) Coverage of dependents; (e) Pre-existing conditions; (f) Termination of insurance; (g) Probationary periods; (h) Limitations;

(i) Exceptions;

(j) Reductions;

(k) Elimination periods; (l) Requirements for replacement; (m) Recurrent conditions; and (n) The definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable and noncancelable.

(2) The director may issue rules that specify prohibited policy provisions not otherwise specifically authorized by statute which in the opinion of the director are unjust, unfair, or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary.

History.

1975, ch. 205, § 3, p. 569; am. 2009, ch. 66, § 3, p. 187.

STATUTORY NOTES

Amendments.

The 2009 amendment, by ch. 66, in the introductory paragraph in subsection (1) and in subsection (2), deleted “and regulations” following “rules”; and, in the introductory paragraph in subsection (1), inserted “group supplemental policies of disability insurance” and substituted “managed care organizations” for “health maintenance organizations.”

§ 41-4204. Minimum standards for benefits. — (1) The director shall issue rules, subject to chapter 52, title 67, Idaho Code, to establish minimum standards for benefits under each of the following categories of coverage in individual policies, group supplemental policies, nongroup subscriber contracts of nonprofit hospital, medical and dental service associations, and nongroup subscriber contracts of managed care organizations other than conversion policies issued pursuant to a contractual conversion privilege under a group policy of disability insurance:

(a) Basic hospital expense coverage; (b) Basic medical-surgical and dental expense coverage; (c) Hospital confinement indemnity coverage; (d) Major medical expense coverage; (e) Disability income protection coverage; (f) Accident only coverage; and (g) Specified disease.

(2) Nothing in this section shall preclude the issuance of any policy or contract which combines two (2) or more of the categories of coverage enumerated in paragraphs (a) through (g) of subsection (1) of this section.

(3) No policy or contract shall be delivered or issued for delivery in this state which does not meet the prescribed minimum standards for the categories of coverage listed in paragraphs (a) through (g) of subsection (1) of this section, which are contained within the policy or contract unless the director finds such policy or contract will be in the public interest and such policy or contract meets the requirements set forth in [section 41-1813, Idaho Code](#).

(4) The director shall prescribe the method of identification of policies and contracts based upon coverages provided.

History.

1975, ch. 205, § 4, p. 569; am. 2009, ch. 66, § 4, p. 187.

STATUTORY NOTES

Amendments.

The 2009 amendment, by ch. 66, in the introductory paragraph in subsection (1), deleted “and regulations” following “rules,” inserted “group

supplemental policies” and substituted “managed care organizations” for “health maintenance organizations”; and, in subsection (1)(g), deleted “or specified accident coverage” from the end.

§ 41-4205. Outline of coverage. — (1) In order to provide for full and fair disclosure in the sale of individual disability insurance policies, group supplemental disability insurance policies, nongroup subscriber contracts of a nonprofit hospital, medical or dental service association, or nongroup subscriber contracts of managed care organizations, no such policy or contract shall be offered, delivered, issued for delivery, continued or renewed in this state unless:

(a) In the case of a direct response insurance product, the outline of coverage described in subsection (2) of this section accompanies the policy;

(b) In all other cases, the outline of coverage described in subsection (2) of this section is delivered to the applicant at the time application is made and an acknowledgment of receipt of certificate of delivery of such outline is provided the insurer with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and clearly state that it is not the policy or contract for which application was made.

(2) The director shall prescribe the format and content of the outline of coverage required by subsection (1) of this section. “Format” means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) A statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in [section 41-4204, Idaho Code](#);

(b) A description of the principal benefits and coverage provided in the policy or contract;

(c) A statement of the exceptions, reductions and limitations contained in the policy or contract;

(d) A statement of the renewal provisions including any reservation by the insurer, nonprofit hospital, medical or dental service association or

managed care organization of a right to change premiums;

(e) A statement that the outline is a summary of the policy, certificate or contract issued or applied for and that the policy, certificate or contract should be consulted to determine governing contractual provisions.

History.

1975, ch. 205, § 5, p. 569; am. 2009, ch. 66, § 5, p. 187.

STATUTORY NOTES

Amendments.

The 2009 amendment, by ch. 66, in the introductory paragraph in subsection (1), inserted “group supplemental disability insurance policies,” “offered,” and “continued or renewed” and substituted “managed care organizations” for “health maintenance organizations”; in subsection (2)(d), substituted “managed care organizations” for “health maintenance organizations”; and, in subsection (2)(e), twice inserted “certificate.”

§ 41-4206. Pre-existing conditions. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised 1975, ch. 205, § 6, p. 569, was repealed by S.L. 2009, ch. 66, § 6.

§ 41-4207. Administrative procedure. — Rules and regulations promulgated pursuant to this act shall be subject to notice and hearing pursuant to [section 41-211, Idaho Code](#), and chapter 52, title 67, Idaho Code.

History.

1975, ch. 205, § 7, p. 569.

STATUTORY NOTES

Compiler's Notes.

The term “this act” near the middle of the section refers to S.L. 1975, Chapter 205, compiled as §§ 41-4201 to 41-4205 and 41-4207.

Section 8 of S.L. 1975, ch. 205, read: “The provisions of this act are hereby declared to be severable, and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

Effective Dates.

Section 9 of S.L. 1975, ch. 205 provided that the act should take effect on and after July 1, 1975.

Chapter 43
IDAHO LIFE AND HEALTH INSURANCE GUARANTY
ASSOCIATION ACT

Sec.

41-4301. Short title.

41-4302. Purpose.

41-4303. Coverage and limitations.

41-4304. Construction.

41-4305. Definitions.

41-4306. Creation of the association.

41-4307. Board of directors.

41-4308. Powers and duties of the association.

41-4309. Assessments.

41-4310. Plan of operation.

41-4311. Duties and powers of the director.

41-4312. Prevention of insolvencies.

41-4313. Credits for assessments paid.

41-4314. Miscellaneous provisions.

41-4315. Examination of the association — Annual report.

41-4316. Tax exemptions.

41-4317. Immunity.

41-4318. Stay of proceedings — Reopening default judgments.

41-4319. Prohibited advertisement of insurance guaranty association act in
commercial sales.

41-4320. Application.

§ 41-4301. Short title. — This chapter shall be known and may be cited as the “Idaho Life and Health Insurance Guaranty Association Act.”

History.

I.C., § 41-4301, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former chapter 43 of Title 41, which comprised the following sections, were repealed by S.L. 2011, ch. 196, § 1, effective July 1 2011.

41-4301. Short title. [**I.C., § 41-4301**, as added by 1977, ch. 217, § 1, p. 636.]

41-4302. Purpose. [**I.C., § 41-4302**, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 1, p. 617; am. 2000, ch. 371, § 3, p. 1224.]

41-4303. Application of chapter. [**I.C., § 41-4303**, as added by 1977, ch. 217, § 1, p. 636; am. 1991, ch. 280, § 1, p. 723; am. 2000, ch. 323, § 1, p. 1090; am. 2000, ch. 371, § 4, p. 1224; am. 2005, ch. 108, § 1, p. 356; am. 2009, ch. 54, § 1, p. 150.]

41-4304. Construction. [**I.C., § 41-4304**, as added by 1977, ch. 217, § 1, p. 636.]

41-4305. Definitions. [**I.C., § 41-4305**, as added by 1977, ch. 217, § 1, p. 636; am. 1991, ch. 280, § 2, p. 723; am. 2009, ch. 54, § 2, p. 150.]

41-4306. Creation of the association. [**I.C., § 41-4306**, as added by 1977, ch. 217, § 1, p. 636.]

41-4307. Board of directors. [**I.C., § 41-4307**, as added by 1977, ch. 217, § 1, p. 636.]

41-4308. Powers and duties of the association. [**I.C., § 41-4308**, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 2, p. 617; am. 2000, ch. 323, § 2, p. 1090; am. 2000, ch. 371, § 5, p. 1224; am. 2009, ch. 54, § 3, p. 150.]

41-4309. Assessments. [I.C., § 41-4309, as added by 1977, ch. 217, § 1, p. 636; am. 1986, ch. 43, § 1, p. 127; am. 2000, ch. 371, § 6, p. 1224; am. 2005, ch. 108, § 2, p. 356.]

41-4310. Plan of operation. [I.C., § 41-4310, as added by 1977, ch. 217, § 1, p. 636.]

41-4311. Duties and powers of the director. [I.C., § 41-4311, as added by 1977, ch. 217, § 1, p. 636.]

41-4312. Prevention of insolvencies. [I.C., § 41-4312, as added by 1977, ch. 217, § 1, p. 636; am. 1987, ch. 292, § 3, p. 617; am. 1990, ch. 213, § 61, p. 480.]

41-4313. Credits for assessments paid. [I.C., § 41-4313, as added by 1977, ch. 217, § 1, p. 636; am. 1994, ch. 239, § 1, p. 751.]

41-4314. Miscellaneous provisions. [I.C., § 41-4314, as added by 1977, ch. 217, § 1, p. 636.]

41-4315. Examination of the association — Annual report. [I.C., § 41-4315, as added by 1977, ch. 217, § 1, p. 636.]

41-4316. Tax exemptions. [I.C., § 41-4316, as added by 1977, ch. 217, § 1, p. 636.]

41-4317. Immunity. [I.C., § 41-4317, as added by 1977, ch. 217, § 1, p. 636.]

41-4318. Stay of proceedings — Reopening default judgments. [I.C., § 41-4318, as added by 1977, ch. 217, § 1, p. 636.]

41-4319. Prohibited advertisement of insurance guaranty association act in sale of insurance. [I.C., § 41-4319, as added by 1977, ch. 217, § 1, p. 636; am. 2009, ch. 54, § 4, p. 150.]

§ 41-4302. Purpose. — (1) The purpose of this chapter is to protect, subject to certain limitations, the persons specified in [section 41-4303\(1\), Idaho Code](#), against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts specified in [section 41-4303\(2\), Idaho Code](#), because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(2) To provide the protection stated in subsection (1) of this section, an association of insurers will pay benefits and continue coverages as provided for and limited by this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

History.

[I.C., § 41-4302](#), as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4302 was repealed. See Prior Laws, § 43-4301.

§ 41-4303. Coverage and limitations. — (1) This chapter shall provide coverage for the policies and contracts specified in subsection (2) of this section:

(a) To persons, except for nonresident certificate holders under group policies or contracts who, regardless of where they reside, are the beneficiaries, assignees or payees of the persons covered under paragraph (b) of this subsection.

(b) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

1. The insurer that issued the policies or contracts is domiciled in this state;

2. The states in which the persons reside have associations similar to the association created by this chapter; and

3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.

(c) For structured settlement annuities specified in subsection (2) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (d) and (e) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under both of the following conditions:

1.(A) The contract owner of the structured settlement annuity is a resident; or

(B) The contract owner of the structured settlement annuity is not a resident; but the insurer that issued the structured settlement annuity is domiciled in this state; and the state in which the contract owner resides has an association similar to the association created in this chapter; and

2. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(d) The provisions of this chapter shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state.

(e) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, the provisions of this chapter shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(2)(a) The provisions of this chapter shall provide coverage to the persons specified in subsection (1) of this section for direct, non-group life, health or annuity policies or contracts and for certificates under direct group policies and contracts and for supplemental contracts to any of these, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

(b) The provisions of this chapter shall not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's corporate bond yield average averaged for that same four (4) year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier; and

2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured including, but not limited to, benefits payable by an employer, association or other person under:

1. A multiple employer welfare arrangement as defined in section 3(40) of the employee retirement income security act of 1974, [29 U.S.C. section 1002\(40\)](#);

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

1. Dividends or experience rating credits;
2. Voting rights; or
3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) A portion of a policy or contract to the extent that the assessments required in [section 41-4309, Idaho Code](#), with respect to the policy or contract are preempted by federal or state law;

(viii) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;
2. Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;
3. Misrepresentations of or regarding policy benefits;
4. Extra-contractual claims; or
5. A claim for penalties or consequential or incidental damages;

(ix) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(x) An unallocated annuity contract;

(xi) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which

the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under the provisions of this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; and

(xii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to 42 U.S.C. part C or 42 U.S.C. part D, commonly known as medicare parts C and D, or any regulations issued pursuant thereto.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b) Subject to the aggregate per life limitation in paragraph (c) of this subsection with respect to one (1) policy or contract:

(i) Three hundred thousand dollars (\$300,000) in life insurance death benefits, but not more than one hundred thousand dollars (\$100,000) in net cash surrender and net cash withdrawal values for life insurance;

(ii) Three hundred thousand dollars (\$300,000) in health insurance claims or benefit payments or one hundred thousand dollars (\$100,000) in net cash surrender and net cash withdrawal values for health benefits, except for major medical insurance as defined in [section 41-4305, Idaho Code](#), and as provided for in subparagraph (iii) of this paragraph;

(iii) Five hundred thousand dollars (\$500,000) for major medical insurance as defined in [section 41-4305, Idaho Code](#);

(iv) Two hundred fifty thousand dollars (\$250,000) in the present value of annuity benefits, including net cash surrender and net cash

withdrawal values;

(v) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars (\$250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

(c) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of three hundred thousand dollars (\$300,000) in benefits with respect to any one (1) life under paragraph (b) of this subsection, except with respect to benefits for major medical insurance as provided in paragraph (b)(iii) of this subsection, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars (\$500,000) with respect to any one (1) life; or

(ii) With respect to one (1) owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars (\$5,000,000) in benefits, regardless of the number of policies and contracts held by the owner; or

(d) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under the provisions of this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(e) For purposes of this act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(4) In performing its obligations to provide coverage under [section 41-4308, Idaho Code](#), the association shall not be required to guarantee,

assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

History.

I.C., § 41-4303, as added by 2011, ch. 196, § 2, p. 558; am. 2018, ch. 192, § 1, p. 418.

STATUTORY NOTES

Prior Laws.

Former § 41-4303 was repealed. See Prior Laws, § 43-4301.

Amendments.

The 2018 amendment, by ch. 192, added paragraph (3)(e).

Federal References.

Medicare parts C and D, referred to in paragraph (2)(b)(xii), are codified as 42 USCS § 1395w-21 et seq. and 42 USCS § 1395w-101, respectively.

Compiler's Notes.

The term “this act” in paragraph (3)(e) refers to S.L. 2018, Chapter 192, which is codified as §§ 41-4303, 41-4308, and 41-4309.

For recent Moody's corporate average yields, referred to in paragraphs (2)(b)(iii)1. and 2., see <http://www.naic.org/research moody.htm>.

For Moody's Investors Service, Inc., see <http://www.moody.com>.

§ 41-4304. Construction. — The provisions of this chapter shall be construed to effect the purpose under [section 41-4302, Idaho Code](#).

History.

[I.C., § 41-4304](#), as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4304 was repealed. See Prior Laws, § 43-4301.

§ 41-4305. Definitions. — As used in this chapter:

(1) “Account” means any of the three (3) accounts maintained pursuant to [section 41-4306, Idaho Code](#).

(2) “Association” means the Idaho life and health insurance guaranty association.

(3) “Authorized assessment” or “authorized,” when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) “Benefit plan” means a specific employee, union or association of natural persons benefit plan.

(5) “Called assessment” or “called,” when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) “Contractual obligation” means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under [section 41-4303, Idaho Code](#).

(7) “Covered policy” means a policy or contract or portion of a policy or contract for which coverage is provided under [section 41-4303, Idaho Code](#).

(8) “Director” means the director of the Idaho department of insurance.

(9) “Extra-contractual claims” shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney’s fees and costs.

(10) “Impaired insurer” means a member insurer:

(a) Deemed by the director after the effective date of this chapter to be potentially unable to fulfill its contractual obligations and not an

insolvent insurer; or

(b) Which, after the effective date of this chapter, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) “Insolvent insurer” means a member insurer which, after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(12)(a) “Major medical insurance” means, solely for purposes of this chapter, health insurance policies, contracts or certificates that are issued to provide hospital and medical-surgical coverage.

(b) “Major medical insurance” shall not include insurance policies, contracts or certificates:

(i) Issued by an insurer providing only accident-only, credit, dental, vision, long-term care or disability income insurance or specified disease or hospital confinement indemnity insurance; or

(ii) For medicare supplement insurance or for coverage supplemental to the coverage provided under the civilian health and medical program of the uniformed services (CHAMPUS).

(13)(a) “Member insurer” means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under [section 41-4303, Idaho Code](#), and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn.

(b) “Member insurer” does not include:

(i) A hospital or medical service corporation or organization, whether profit or nonprofit;

(ii) A fraternal benefit society;

(iii) A mandatory state pooling plan;

(iv) A mutual assessment company or other person that operates on an assessment basis;

- (v) An insurance exchange;
- (vi) An organization that issues charitable gift annuities under [section 41-120, Idaho Code](#);
- (vii) A mutual benefit association;
- (viii) A reciprocal insurer;
- (ix) A limited managed care plan;
- (x) A self-funded health care plan; or
- (xi) A consumer operated and oriented plan established under section 1322 of the patient protection and affordable care act, [P.L. 111-148](#).

(14) “Moody’s corporate bond yield average” means the monthly average corporates as published by Moody’s investors service, inc., or any successor thereto.

(15) “Owner,” “policy owner” or “contract owner” means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(16) “Person” means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(17)(a) “Premiums” means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits.

(b) “Premiums” does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under [section 41-4303\(2\), Idaho Code](#), except that assessable premium shall not be reduced on account of [section 41-4303\(2\)\(b\)\(iii\), Idaho Code](#), relating to interest limitations and section 41-4303(3)(b), (c) and (d), Idaho Code, relating to limitations with

respect to one (1) individual, one (1) participant and one (1) contract owner. “Premiums” shall not include:

- (i) Premiums on an unallocated annuity contract; or
- (ii) With respect to multiple non-group policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars (\$5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(18)(a) “Principal place of business” of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

- (i) The state in which the primary executive and administrative headquarters of the entity is located;
- (ii) The state in which the principal office of the chief executive officer of the entity is located;
- (iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;
- (iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;
- (v) The state from which the management of the overall operations of the entity is directed; and
- (vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors contained in subparagraphs (i) through (v) of this paragraph.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) “Principal place of business” of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(19) “Receivership court” means the court in the insolvent or impaired insurer’s state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(20) “Resident” means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (a) residents of foreign countries, or (b) residents of United States possessions, territories or protectorates that do not have an association similar to the association created in this chapter, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(21) “State” means a state or a commonwealth of the United States, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(22) “Structured settlement annuity” means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(23) “Supplemental contract” means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or

contract.

(24) “Unallocated annuity contract” means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

History.

I.C., § 41-4305, as added by 2011, ch. 196, § 2, p. 558; am. 2015, ch. 281, § 1, p. 1144.

STATUTORY NOTES

Prior Laws.

Former § 41-4305 was repealed. See Prior Laws, § 43-4301.

Amendments.

The 2015 amendment, by ch. 281, added paragraph (13)(b)(xi).

Federal References.

For civilian health and medical program for uniformed services (CHAMPUS), referred to in paragraph (12)(b)(ii), see **10 USCS § 1071**.

Section 1322 of the patient protection and affordable care act, **P.L. 111-148**, referred to in paragraph (13)(b)(xi), is codified as **42 USCS § 18042**.

Compiler’s Notes.

The phrase “the effective date of this chapter” in paragraphs (10)(a) and (10)(b) and in subsection (11) refers to the effective date of S.L. 2011, Chapter 196, which was effective July 1, 2011.

For recent Moody’s corporate average yields, referred to in subsection (14), see *<http://www.naic.org/research moody.htm>*.

For Moody’s Investors Service, Inc., referred to in subsection (14), see *<http://www.moody.com>*.

§ 41-4306. Creation of the association. — (1) This chapter continues the existence of the nonprofit legal entity known as the Idaho life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under [section 41-4310, Idaho Code](#), and shall exercise its powers through a board of directors provided for under [section 41-4307, Idaho Code](#). For purposes of administration and assessment, the association shall continue the existence and maintenance of three (3) accounts:

(a) Life insurance account; (b) Health insurance account, formerly designated the “disability insurance account”; and (c) Annuity account.

(2) The association shall come under the immediate supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state.

History.

[I.C., § 41-4306](#), as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4306 was repealed. See Prior Laws, § 43-4301.

§ 41-4307. Board of directors. — (1) The board of directors of the association shall consist of not fewer than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board of directors shall be selected by member insurers subject to the approval of the director. Vacancies on the board of directors shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the director.

(2) In approving selections, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board of directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board of directors shall not otherwise be compensated by the association for their services.

History.

I.C., § 41-4307, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4307 was repealed. See Prior Laws, § 43-4301.

§ 41-4308. Powers and duties of the association. — (1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; and

(b) Provide such moneys, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)1. Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after

the date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for non-group policies and contracts, or group policy owners with respect to group policies and contracts, thirty (30) days' notice of the termination, pursuant to subparagraph (i) of this paragraph, of the benefits provided;

(iii) With respect to non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv) of this paragraph, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class:

(iv)1. In providing the substitute coverage required under subparagraph (iii) of this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy;

2. Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy; and

3. The association may reinsure any alternative or reissued policy;

(v)1. Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance director. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten; and

3. Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance director;

(vii) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association; and

(viii) When proceeding under this paragraph (b) of this subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with [section 41-4303\(2\)\(b\)\(iii\), Idaho Code](#).

(c) With respect to health benefit plans that are subject to state or federal guaranteed issue requirements, the association may terminate the policies upon entry of an order of liquidation with approval of the director.

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued

policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter shall not apply where any guarantee protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; or

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the

moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the director for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to chapter 8, title 41, Idaho Code, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of state assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (2) of this section, the director shall have the powers and duties of the association under this chapter with respect to the insolvent insurer.

(9) The association may render assistance and advice to the director, upon the director's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or

insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) A person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require a written instrument of assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon the person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(c) In addition to paragraphs (a) and (b) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under [Internal Revenue Code, section 130](#).

(d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable

by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in paragraphs (a) through (d) of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(12) In addition to the rights and powers elsewhere in this chapter, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under [section 41-4309, Idaho Code](#), and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this chapter and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(g) Reorganize itself with the prior written approval of the director from a nonprofit association into a corporation or other legal form of nonprofit entity permitted by the laws of the state of Idaho;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; and

(i) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(13) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation.

(15) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(16) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under this chapter shall be in Ada county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the provisions of this chapter.

(18) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsection (1) or (2) of this section, the association may, subject to approval of the receivership court, issue

substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(i) A fixed interest rate;

(ii) Payment of dividends with minimum guarantees; or

(iii) A different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

History.

I.C., § 41-4308, as added by 2011, ch. 196, § 2, p. 558; am. 2018, ch. 192, § 2, p. 418.

STATUTORY NOTES

Prior Laws.

Former § 41-4308 was repealed. See Prior Laws, § 43-4301.

Amendments.

The 2018 amendment, by ch. 192, added paragraph (2)(c).

Federal References.

Internal Revenue Code, section 130, referred to in paragraph (11)(c), is codified as **26 USCS § 130**.

§ 41-4309. Assessments. — (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board of directors finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at eight percent (8%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under [section 41-4308, Idaho Code](#), with regard to an impaired or an insolvent insurer.

(3)(a) The amount of a class A assessment shall be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board of directors may provide that it be credited against future class B assessments. The total of all non-pro rata assessments shall not exceed three hundred dollars (\$300) per member insurer in any one (1) calendar year.

(b) The amount of a class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of a class B assessment for long-term care insurance shall be allocated according to a methodology selected by the association and approved by the director, which methodology shall provide for fifty percent (50%) of the assessment to be allocated to health member

insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessments bears to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under this subsection and subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a) The total of all class B assessments authorized by the association with respect to a member insurer for each account shall not in one (1) calendar year exceed two percent (2%) of such insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the association in an account, does not

provide in any one (1) year in an account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(b) The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(6) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments.

A reasonable amount, as determined by the board of directors in its discretion, may be retained by the association in any account to provide funds for the continuing and future expenses of the association and for future loss claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association shall issue to each insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution in a form prescribed by the director for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the

protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with the request.

History.

I.C., § 41-4309, as added by 2011, ch. 196, § 2, p. 558; am. 2018, ch. 192, § 3, p. 418.

STATUTORY NOTES

Prior Laws.

Former § 41-4309 was repealed. See Prior Laws, § 43-4301.

Amendments.

The 2018 amendment, by ch. 192, designated the former last sentence in paragraph (3)(a) as present paragraph (3)(b), inserted the exception near the

beginning of present paragraph (3)(b), inserted present paragraph (3)(c), and redesignated the subsequent paragraphs accordingly.

§ 41-4310. Plan of operation. — (1) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the director's written approval or unless it has not been disapproved within thirty (30) days.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under [section 41-4307, Idaho Code](#);

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the director;

(f) Establish any additional procedures for assessments under [section 41-4309, Idaho Code](#); and

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under [section 41-4308\(12\)\(c\), Idaho Code](#), and [section 41-4309, Idaho Code](#), are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this

subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

History.

I.C., § 41-4310, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4310 was repealed. See Prior Laws, § 43-4301.

§ 41-4311. Duties and powers of the director. — In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The director shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer; and

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this chapter.

(2) The director may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the director may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars (\$100) per month.

(3) A final action of the board of directors or the association may be appealed to the director by a member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the director shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the director.

(4) The liquidator, rehabilitator or conservator of an impaired or insolvent insurer may notify all interested persons of the effect of this chapter.

History.

I.C., § 41-4311, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4311 was repealed. See Prior Laws, § 43-4301.

§ 41-4312. Prevention of insolvencies. — (1) To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the director to:

(a) Notify the insurance directors or commissioners of all the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the director takes any of the following actions against a member insurer:

(i) Revokes a license;

(ii) Suspends a license; or

(iii) Makes a formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

(b) Report to the board of directors when the director has taken any of the actions set forth in paragraph (a) of this subsection or has received a report from any other director indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another director.

(c) Report to the board of directors when the director has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(d) Furnish to the board of directors the national association of insurance commissioners (NAIC) insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board of directors may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the director or other lawful authority.

(2) The director may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the director regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors may, upon majority vote, notify the director of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer insolvencies.

History.

I.C., § 41-4312, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4312 was repealed. See Prior Laws, § 43-4301.

Compiler's Notes.

For more information on the national association of insurance commissioners, see <http://naic.org/>.

The letters “NAIC” enclosed in parentheses so appeared in the law as enacted.

§ 41-4313. Credits for assessments paid. — (1) A member insurer may offset against its premium tax liability to this state an assessment described in [section 41-4309\(8\), Idaho Code](#), to the extent of twenty percent (20%) of the amount of the assessment for each of five (5) calendar years beginning with the premium tax due under [section 41-402\(4\), Idaho Code](#), with respect to the year of payment of the assessment and thereafter with the premium tax due under [section 41-402\(4\), Idaho Code](#), during each of the four (4) succeeding years. An allowable offset, or portion thereof, not used in any calendar year cannot be carried over or back to any other year.

(2) Any sums acquired by refund, pursuant to [section 41-4309\(6\), Idaho Code](#), from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and are not then needed for purposes of this chapter, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the general account of the state operating fund.

History.

[I.C., § 41-4313](#), as added by 2011, ch. 196, § 2, p. 558; am. 2013, ch. 265, § 2, p. 650.

STATUTORY NOTES

Cross References.

General fund, § 67-1205.

State treasurer, § 67-1201 et seq.

Prior Laws.

Former § 41-4313 was repealed. See Prior Laws, § 43-4301.

Amendments.

The 2013 amendment, by ch. 265, substituted “five (5) calendar years beginning with the premium tax due under [section 41-402\(4\), Idaho Code](#), with respect to the year of payment of the assessment and thereafter with

the premium tax due under [section 41-402\(4\), Idaho Code](#), during each of the four (4) succeeding years” for “the five (5) calendar years following the year in which the assessment was paid” in the first sentence in subsection (1) and deleted former subsection (3), which read: “Any sums acquired by refund, pursuant to [section 41-4309\(6\), Idaho Code](#), from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in subsection (1) of this section, and are not then needed for purposes of this chapter, shall be paid by the association to the director and by him deposited with the state treasurer for credit to the general account of the state operating fund.”

§ 41-4314. Miscellaneous provisions. — (1) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under [section 41-4308, Idaho Code](#). The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except upon the:

- (a) Termination of the impairment or insolvency of the insurer; or
- (b) Order of a court of competent jurisdiction.

Nothing in this subsection shall limit the duty of the association to render a report of its activities under [section 41-4315, Idaho Code](#).

(3) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to [section 41-4308\(11\), Idaho Code](#). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer, as established in subsection (3) of this section and consistent with [section 41-3334, Idaho Code](#), the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within

one hundred twenty (120) days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under [section 41-4308, Idaho Code](#), with respect to the insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b), (c) and (d) of this subsection.

(b) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to

the amount of distributions which would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under paragraph (c) of this subsection is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

History.

I.C., § 41-4314, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4314 was repealed. See Prior Laws, § 43-4301.

§ 41-4315. Examination of the association — Annual report. — The association shall be subject to examination and regulation by the director. The board of directors shall submit to the director each year, not later than May 1 of each year, a financial report in a form approved by the director and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

History.

I.C., § 41-4315, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4315 was repealed. See Prior Laws, § 43-4301.

§ 41-4316. Tax exemptions. — The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

History.

I.C., § 41-4316, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4316 was repealed. See Prior Laws, § 43-4301.

§ 41-4317. Immunity. — There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors or the director or the director's representatives, for any action or omission by them in the performance of their powers and duties under this chapter. This immunity shall extend to the participation in any organization of one (1) or more other state associations of similar purposes and to any such organization and its agents or employees.

History.

I.C., § 41-4317, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4317 was repealed. See Prior Laws, § 43-4301.

§ 41-4318. Stay of proceedings — Reopening default judgments. —

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

History.

I.C., § 41-4318, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4318 was repealed. See Prior Laws, § 43-4301.

§ 41-4319. Prohibited advertisement of insurance guaranty association act in commercial sales. — No person, including an insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the Idaho life and health insurance guaranty association act. Provided however, that this section shall not apply to the Idaho life and health insurance guaranty association or any other entity which does not sell or solicit insurance. This section shall also not prohibit the furnishing of written information that is in a form prepared by the association and approved by the director upon request of the policy owner.

History.

I.C., § 41-4319, as added by 2011, ch. 196, § 2, p. 558.

STATUTORY NOTES

Prior Laws.

Former § 41-4319 was repealed. See Prior Laws, § 43-4301.

§ 41-4320. Application. — This chapter shall apply to coverage the guaranty association provides in connection with any member insurer that was first placed under an order of liquidation on or after January 1, 2011.

History.

I.C., § 41-4320, as added by 2011, ch. 196, § 2, p. 558.

Chapter 44
MEDICARE SUPPLEMENT INSURANCE MINIMUM
STANDARDS

Sec.

41-4401. Purpose.

41-4402. Definitions.

41-4403. Applicability and scope.

41-4404. Standards for policy provisions and authority to promulgate rules.

41-4405. Loss ratio standards.

41-4406. Disclosure standards.

41-4407. Notice of free examination.

41-4408. Filing requirements for advertising.

41-4409. Administrative procedures.

41-4410. Penalties.

41-4411. Separability.

§ 41-4401. Purpose. — The purpose of this chapter shall be to provide reasonable standardization and simplification of terms and coverages of medicare supplement disability insurance policies and enrollee contracts of managed care organizations, to facilitate public understanding and comparison, to eliminate provisions contained in disability insurance policies and enrollee contracts of managed care organizations which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such coverages.

History.

I.C., § 41-4401, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

The following sections of former Chapter 44 were repealed by S.L. 1999, ch. 102, § 1, p. 323, effective January 1, 1999: § 41-4401. **I.C., § 41-4401**, as added by 1981, ch. 68, § 1, p. 98.

§ 41-4402. **I.C., § 41-4402**, as added by 1981, ch. 68, § 1, p. 98; am. 1989, ch. 130, § 1, p. 280; am. 1990, ch. 323, § 1, p. 882; am. 1992, ch. 247, § 1, p. 724.

§ 41-4402A. **I.C., § 41-4402A**, as added by 1992, ch. 247, § 2, p. 724.

§ 41-4403. **I.C., § 41-4403**, as added by 1981, ch. 68, § 1, p. 98; am. 1989, ch. 130, § 2, p. 280; am. 1992, ch. 247, § 3, p. 724; am. 1995, ch. 254, § 3, p. 831.

§ 41-4404. **I.C., § 41-4404**, as added by 1981, ch. 68, § 1, p. 98; am. 1989, ch. 130, § 3, p. 280; am. 1990, ch. 323 § 2, p. 882; am. 1992, ch. 247, § 4, p. 724.

§ 41-4405. **I.C., § 41-4405**, as added by 1981, ch. 68, § 1, p. 98; am. 1989, ch. 130, § 4, p. 280; am. 1990, ch. 323, § 3, p. 882; am. 1992, ch. 247, § 5, p. 724.

§ 41-4406. **I.C., § 41-4406**, as added by 1981, ch. 68, § 1, p. 98; am. 1989, ch. 130, § 5, p. 280; am. 1992, ch. 247, § 6, p. 724.

§ 41-4407. **I.C., § 41-4407**, as added by 1994, ch. 403, § 1, p. 1268.

§ 41-4408. **I.C., § 41-4408**, as added by 1981, ch. 68, § 1, p. 98; am. 1989, ch. 130, § 6, p. 280; am. 1992, ch. 247, § 8, p. 724.

§ 41-4409. **I.C., § 41-4409**, as added by 1981, ch. 68, § 1, p. 98; am. 1992, ch. 247, § 9, p. 724.

§ 41-4410. **I.C., § 41-4410**, as added by 1989, ch. 130, § 7, p. 280; am. 1992, ch. 247, § 10, p. 724.

§ 41-4411. **I.C., § 41-4411** as added by 1990, ch. 323, § 4, p. 882; am. 1992, ch. 247, § 11, p. 724.

§ 41-4412. **I.C., § 41-4412** as added by 1990, ch. 323, § 4, p. 882; am. 1992, ch. 247, § 11, p. 724.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

OPINIONS OF ATTORNEY GENERAL

Applicability.

Medicare supplement policies may be written for persons eligible for medicare by reason of disability. OAG 87-8.

§ 41-4402. Definitions. — (1) “Applicant” means:

(a) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(b) In the case of a group medicare supplement policy, the proposed certificate holder.

(2) “Certificate” means, for the purposes of this chapter, any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) “Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) “Issuer” includes insurance companies, fraternal benefit societies, managed care organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(5) “Medicare” means the “Health Insurance for the Aged Act,” title XVIII of the social security amendments of 1965, as then constituted or later amended.

(6) “Medicare supplement policy” means a group or individual policy of accident and sickness insurance or an enrollee contract under a managed care organization, other than a policy issued pursuant to a contract under section 1876 of the federal social security act (42 U.S.C. section 1395 et seq.), or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare.

(7) “Policy form” means the form on which the policy is delivered or issued for delivery by the issuer.

History.

I.C., § 41-4402, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4402 was repealed. See Prior Laws, § 41-4401.

Federal References.

The Health Insurance for the Aged Act, title XVIII of the social security amendments of 1965, referred to in subsection (5), is codified as [42 USCS § 1395 et seq.](#)

Section 1876 of the federal social security act, referred to in subsection (6), is codified as [42 USCS § 1396mm.](#)

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4403. Applicability and scope. — (1) Except as otherwise specifically provided this chapter shall apply to:

(a) All medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this act; and

(b) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(2) This chapter shall not apply to a policy of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(3) Except as otherwise specifically provided in [section 41-4406\(4\), Idaho Code](#), the provisions of this chapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons when the policies are not marketed or held to be medicare supplement policies or benefit plans.

History.

[I.C., § 41-4403](#), as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4403 was repealed. See Prior Laws, § 41-4401.

Compiler's Notes.

The phrase “the effective date of this act” in paragraph (1)(a) refers to the effective date of S.L. 1999, Chapter 102, which was effective January 1, 1999.

§ 41-4404. Standards for policy provisions and authority to promulgate rules. — (1) No medicare supplement policy or certificate in force in this state shall contain benefits that duplicate benefits provided by medicare.

(2) Notwithstanding any other provision of law of this state, a medicare supplement policy or certificate shall not exclude or limit benefits for loss incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(3) The director may adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this state, including chapter 21, title 41, Idaho Code, disability insurance policies. No requirement of the insurance code relating to minimum required policy benefits, other than the minimum standards contained in this chapter, shall apply to medicare supplement policies and certificates. The standards may cover, but not be limited to: (a) Terms of renewability;

(b) Initial and subsequent conditions of eligibility; (c) Nonduplication of coverage;

(d) Probationary periods;

(e) Benefit limitations, exceptions and reductions; (f) Elimination periods;

(g) Requirements for replacement; (h) Recurrent conditions;

(i) Definition of terms;

(j) Open enrollment;

(k) Attained age rating prohibited.

(4) The director may adopt reasonable rules to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices, for medicare supplement policies and certificates.

(5) The director may adopt from time to time reasonable rules necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder including, but not limited to: (a) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements; (b) Establishing a uniform methodology for calculating and reporting loss ratios; (c) Assuring public access to all policies, premiums and loss ratio information of issuers of medicare supplement insurance; (d) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; (e) Establishing a policy for holding public hearings prior to approval of premium increases; and (f) Establishing standards for medicare select policies and certificates.

(6) The director may adopt reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the director, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

History.

I.C., § 41-4404, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4404 was repealed. See Prior Laws, § 41-4401.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4405. Loss ratio standards. — Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The director may issue reasonable rules to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

History.

I.C., § 41-4405, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4405 was repealed. See Prior Laws, § 41-4401.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4406. Disclosure standards. — (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(2) The director may prescribe the format and content of the outline of coverage required by this section. For purposes of this section, “format” means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage shall include:

- (a) A description of the principal benefits and coverage provided in the policy;
- (b) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums;
- (c) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) The director may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer’s ability to select the most appropriate coverage and improve the buyer’s understanding of medicare. Except in the case of direct response insurance policies, the director may require by rule that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the director may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare, but in no event later than the time of policy delivery.

(4) The director may adopt rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement

coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) Medicare supplement policies; or

(b) Disability income policies.

(5) The director may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, or certificates by persons eligible for medicare.

History.

I.C., § 41-4406, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4406 was repealed. See Prior Laws, § 41-4401.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4407. Notice of free examination. — Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. A refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

History.

I.C., § 41-4407, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4407 was repealed. See Compiler's note, § 41-4401.

Another former § 41-4407, which comprised **I.C., § 41-4407**, as added by 1981, ch. 68, § 1, p. 98, was repealed by S.L. 1992, ch. 247, § 7, p. 724.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4408. Filing requirements for advertising. — Every issuer of medicare supplement insurance policies or certificates in this state shall provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the director of the Idaho department of insurance for review or approval by the director to the extent it may be required under state law.

History.

I.C., § 41-4408, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4408 was repealed. See Prior Laws, § 41-4401.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4409. Administrative procedures. — Rules adopted pursuant to this chapter shall be subject to the provisions of chapter 52, title 67, Idaho Code.

History.

I.C., § 41-4409, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4409 was repealed. See Prior Laws, § 41-4401.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4410. Penalties. — In addition to any other applicable penalties for violations of the insurance code, the director may require issuers violating any provision of this chapter or rules promulgated pursuant to this chapter to cease marketing any medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require the issuer to take actions necessary to comply with the provisions of this chapter, or both.

History.

I.C., § 41-4410, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4410 was repealed. See Prior Laws, § 41-4401.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

RESEARCH REFERENCES

ALR. — State criminal prosecution against medical practitioner for fraud in connection with claims under medicaid, medicare, or similar welfare program for providing medical services. 79 A.L.R.6th 125.

§ 41-4411. Separability. — If any provision of this act or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of the act and the application of the provision to other persons or circumstances shall not be affected.

History.

I.C., § 41-4411, as added by 1999, ch. 102, § 2, p. 323.

STATUTORY NOTES

Prior Laws.

Former § 41-4411 was repealed. See Prior Laws, § 41-4401.

Compiler's Notes.

The terms “this act” and “the act” refer to S.L. 1999, Chapter 102, which is codified as §§ 41-4401 to 41-4411.

Effective Dates.

Section 3 of S.L. 1999, ch. 102 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

Chapter 45 MOTOR CLUBS

Sec.

41-4501 — 41-4529. [Repealed.]

§ 41-4501 — 41-4529. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 1997, ch. 383, § 1, effective July 1, 1997.

§ 41-4501. Definitions, which comprised I.C., § 41-4501, as added by 1988, ch. 265, § 503, p. 549.

§§ 41-4502 — 41-4528. Motor clubs — License and regulation — Deposit and maintenance of securities — Certificate of authority — Revocation, suspension or refusal to continue certificate — Service contracts — Club agent, licensing procedure — Hearings and appeals — Review of annual statement — Penalty for violations — Deposit of moneys collected, which comprised 1965, ch. 264, §§ 2 to 28; am. 1980, ch. 268, §§ 1 to 3 p. 407; am 1984, ch. 252, § 1, p. 603; am. and redesisg. 1988, ch. 265, §§ 504 to 530, p. 549.

§ 41-4529. Examination, which comprised I.C., § 49-2331, as added by 1977, ch. 187, § 1, p. 519; am. & redesisg. 1988, ch. 265, § 531, p. 549.

Chapter 46

LONG-TERM CARE INSURANCE ACT

Sec.

41-4601. Purpose.

41-4602. Scope.

41-4603. Definitions.

41-4604. Extraterritorial jurisdiction — Group long-term care insurance.

41-4605. Disclosure and performance standards for long-term care insurance.

41-4606. Incontestability period.

41-4607. Nonforfeiture benefits.

41-4608. Authority to promulgate rules.

41-4609. Administrative procedures.

41-4610. Severability.

41-4611. Penalties.

§ 41-4601. Purpose. — The purpose of this chapter is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

History.

I.C., § 41-4601, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

The following sections of former Chapter 46 were repealed by S.L. 1999, ch. 98, § 1, effective January 1, 1999:

§ 41-4601. I.C., § 41-4601, as added by 1988, ch. 181, § 1, p. 314.

§ 41-4602. I.C., § 41-4602, as added by 1988, ch. 181, § 1, p. 314.

§ 41-4603. I.C., § 41-4603, as added by 1988, ch. 181, § 1, p. 314; am. 1990, ch. 285, § 1, p. 796; am. 1997, ch. 321, § 7, p. 948.

§ 41-4604. I.C., § 41-4604, as added by 1988, ch. 181, § 1, p. 314.

§ 41-4605. I.C., § 41-4605, as added by 1988, ch. 181, § 1, p. 314; am. 1990, ch. 230, § 1, p. 608 ; am. 1990, ch. 285, § 2, p. 792; am. 1991, ch. 271, § 1, p. 682; am. 1996, ch. 222, § 1, p. 727; am. 1997, ch. 321, § 8, p. 948.

§ 41-4606. I.C., § 41-4606, as added by 1988, ch. 181, § 1, p. 314; am. 1997, ch. 321, § 9, p. 948.

§ 41-4607. I.C., § 41-4607, as added by 1997, ch. 321, § 10, p. 948.

§ 41-4608. I.C., § 41-4608, as added by 1997, ch. 321, § 11, p. 948.

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

§ 41-4602. Scope. — The requirements of this chapter shall apply to policies delivered or issued for delivery in this state on or after the effective date of this chapter. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable insurance laws insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance.

History.

I.C., § 41-4602, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

Former § 41-4602 was repealed. See Prior Laws, § 41-4601.

Compiler's Notes.

The phrase “the effective date of this chapter” in the first sentence refers to the effective date of S.L. 1999, Chapter 98, which was effective January 1, 1999.

§ 41-4603. Definitions. — Unless the context requires otherwise, the definitions in this section apply throughout this chapter.

(1) “Applicant” means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and (b) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) “Certificate” means, for the purposes of this chapter, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(3) “Director” means the director of the department of insurance of this state.

(4) “Group long-term care insurance” means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(a) One (1) or more employers or labor organizations, or to a trust or to the trustees of a fund established by one (1) or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the labor organizations; or (b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association: (i) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and (ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(c) An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one (1) or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the director that the association or associations have at the outset a minimum of one hundred (100) persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one (1) year; and have a constitution and bylaws

which provide that: (i) The association or associations hold regular meetings not less than annually to further purposes of the members; (ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) The members have voting privileges and representation on the governing board and committees.

Sixty (60) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements.

(d) A group other than as described in paragraphs (a), (b) and (c) of this subsection, subject to a finding by the director that: (i) The issuance of the group policy is not contrary to the best interest of the public; (ii) The issuance of the group policy would result in economies of acquisition or administration; and (iii) The benefits are reasonable in relation to the premiums charged.

(5) “Long-term care insurance” means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, managed care organizations, or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard

to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one (1) or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this chapter.

(6) “Policy” means, for the purposes of this chapter, any policy, contract, enrolled member agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, managed care organization, or any similar organization.

History.

I.C., § 41-4603, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

Former § 41-4603 was repealed. See Prior Laws, § 41-4601.

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4604. Extraterritorial jurisdiction — Group long-term care insurance. — No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in [section 41-4603\(4\)\(d\), Idaho Code](#), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

History.

[I.C., § 41-4604](#), as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

Former § 41-4604 was repealed. See Prior Laws, § 41-4601.

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4605. Disclosure and performance standards for long-term care insurance. — (1) The director may adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

(2) No long-term care insurance policy may:

(a) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(3) Preexisting condition:

(a) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in [section 41-4603\(4\)\(a\), Idaho Code](#), shall use a definition of “preexisting condition” which is more restrictive than the following: preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in [section 41-4603\(4\)\(a\), Idaho Code](#), may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or

confinement begins within six (6) months following the effective date of coverage of an insured person.

(c) The director may extend the limitation periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of “preexisting condition” does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (3)(b) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (3)(b) of this section.

(4) Prior hospitalization/institutionalization:

(a) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(i) Conditions eligibility for any benefits on a prior hospitalization requirement;

(ii) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(iii) Conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.

(b)(i) A long-term care insurance policy containing postconfinement, postacute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled “limitations or conditions on eligibility for benefits” such limitations or conditions, including any required number of days of confinement.

(ii) A long-term care insurance policy or rider which conditions eligibility for noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

(iii) A long-term care insurance policy or rider containing a benefit advertised, marketed, or offered as a home health care or home care benefit may not condition receipt of benefits on a prior institutionalization requirement.

(5) The director may adopt rules establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the rule.

(6) Right to return — Free look: Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in [section 41-4603\(4\)\(a\), Idaho Code](#), the applicant is not satisfied for any reason.

(7)(a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(i) The director shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(ii) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(iii) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment

form.

(iv) In the case of a policy issued to a group defined in [section 41-4603\(4\)\(a\), Idaho Code](#), an outline of coverage shall not be required to be delivered, provided that the information described in paragraphs (b) (i) through (b)(vi) of this subsection is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the director.

(b) The outline of coverage shall include:

(i) A description of the principal benefits and coverage provided in the policy;

(ii) A statement of the principal exclusions, reductions and limitations contained in the policy;

(iii) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(iv) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(v) A description of the terms under which the policy or certificate may be returned and premium refunded; and

(vi) A brief description of the relationship of cost of care and benefits.

(8) A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(c) A statement that the group master policy determines governing contractual provisions.

(9) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

- (a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
- (b) An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits if any, for each covered person;
- (c) Any exclusions, reductions and limitations on benefits for long-term care;
- (d) A statement that any long-term care inflation protection option as defined by the long-term care insurance rule is not available under this policy.
- (e) If applicable to the policy type, the summary shall also include:
 - (i) A disclosure of the effects of exercising other rights under the policy;
 - (ii) A disclosure of guarantees related to long-term care costs of insurance charges;
 - (iii) Current and projected maximum lifetime benefits.

(10) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

- (a) Any long-term care benefits paid out during the month;
- (b) An explanation of any changes in the policy, *e.g.* death benefits or cash values, due to long-term care benefits being paid out; and
- (c) The amount of long-term care benefits existing or remaining.

(11) Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this chapter.

History.

I.C., § 41-4605, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

Former § 41-4605 was repealed. See Prior Laws, § 41-4601.

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

§ 41-4606. Incontestability period. — (1) For a policy or certificate that has been in force for less than six (6) months an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

(2) For a policy or certificate that has been in force for at least six (6) months but less than two (2) years an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

(3) After a policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(4)(a) No long-term care insurance policy or certificate may be field issued based on medical or health status.

(b) For purposes of this section, “field issued” means a policy or certificate issued by an agent or a third party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

(5) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(6) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by [section 41-1905, Idaho Code](#), as it pertains to incontestability. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

History.

I.C., § 41-4606, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

Former § 41-4606 was repealed. See Prior Laws, § 41-4601.

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

§ 41-4607. Nonforfeiture benefits. — (1) Except as provided in subsection (2) of this section, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(2) When a group long-term care insurance policy is issued, the offer required in subsection (1) of this section shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in [section 41-4603\(4\)\(d\), Idaho Code](#), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(3) The director shall promulgate rules specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding a contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection (1) of this section.

History.

[I.C., § 41-4607](#), as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

Former § 41-4607 was repealed. See Prior Laws, § 41-4601.

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

§ 41-4608. Authority to promulgate rules. — The director shall issue reasonable rules to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance.

History.

I.C., § 41-4608, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Prior Laws.

Former § 41-4608 was repealed. See Prior Laws, § 41-4601.

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4609. Administrative procedures. — Rules adopted for the implementation and administration of this chapter shall be in accordance with the provisions of chapter 52, title 67, Idaho Code.

History.

I.C., § 41-4609, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

RESEARCH REFERENCES

Idaho Law Review. — Paying for Long-Term Care in the Gem State, Andrew M. Hyer. 48 Idaho L. Rev. 351 (2012).

§ 41-4610. Severability. — If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

History.

I.C., § 41-4610, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

§ 41-4611. Penalties. — In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars (\$10,000), whichever is greater.

History.

I.C., § 41-4611, as added by 1999, ch. 98, § 2, p. 303.

STATUTORY NOTES

Effective Dates.

Section 3 of S.L. 1999, ch. 98 declared an emergency retroactively to January 1, 1999 and approved March 18, 1999.

Chapter 47

SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

Sec.

41-4701. Short title.

41-4702. Purpose.

41-4703. Definitions.

41-4704. Applicability and scope.

41-4705. Establishment of classes of business.

41-4706. Restrictions relating to premium rates.

41-4707. Renewability of coverage.

41-4708. Availability of coverage — Preexisting conditions — Portability.

41-4708A. [Reserved.]

41-4708B. Conversion plan — When required.

41-4709. Notice of intent to operate as a risk-assuming carrier or a reinsuring carrier.

41-4710. Application to become a risk-assuming carrier.

41-4711. Small employer health reinsurance program.

41-4712. Small employer health benefit plans.

41-4713. Periodic market evaluation.

41-4714. Waiver of certain state laws. [Repealed.]

41-4715. Administrative procedures.

41-4716. Standards to assure fair marketing.

41-4717. Health insurance coverage for dependent children. [Repealed.]

41-4718. Catastrophic plans. [Repealed.]

Idaho Code § 41-4701

§ 41-4701. Short title. — This chapter shall be known and may be cited as the “Small Employer Health Insurance Availability Act.”

History.

I.C., § 41-4701, as added by 1993, ch. 176, § 1, p. 435.

§ 41-4702. Purpose. — The purpose and intent of this chapter is to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

History.

I.C., § 41-4702, as added by 1993, ch. 176, § 1, p. 435; am. 2000, ch. 472, § 1, p. 1602.

§ 41-4703. Definitions. — As used in this chapter:

(1) “Actuarial certification” means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of [section 41-4706, Idaho Code](#), based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) “Agent” means a producer as defined in [section 41-1003\(8\), Idaho Code](#).

(4) “Base premium rate” means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) “Board” means the board of directors of the small employer [health] reinsurance program and the individual high risk reinsurance pool as provided for in [section 41-5502, Idaho Code](#).

(6) “Carrier” means any entity that provides, or is authorized to provide, health insurance in this state. For the purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(7) “Case characteristics” means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small

employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(8) “Catastrophic health benefit plan” means a higher limit health benefit plan developed pursuant to [section 41-4712, Idaho Code](#).

(9) “Class of business” means all or a separate grouping of small employers established pursuant to [section 41-4705, Idaho Code](#).

(10) “Control” shall be defined in the same manner as in [section 41-3802\(2\), Idaho Code](#).

(11) “Dependent” in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives more than one-half (½) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(12) “Director” means the director of the department of insurance of the state of Idaho.

(13) “Eligible employee” means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours or, by agreement between the employer and the carrier, an employee who works between twenty (20) and thirty (30) hours per week. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, seasonal or substitute basis. The term eligible employee may include public officers and public employees without regard to the number of hours worked when designated by a small employer.

(14) “Established geographic service area” means a geographic area, as approved by the director and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(15) “Health benefit plan” means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health benefit plan does not include policies or certificates of insurance for

specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issues for a period of twelve (12) months or less.

(16) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty (30) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, or the involuntary termination of the qualifying previous coverage; and

(iii) The individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage.

(b) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

(d) The individual first becomes eligible.

(e) If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:

(i) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) In the case of a dependent's birth, as of the date of such birth; or

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(18) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(19) "Plan of operation" means the plan of operation of the program established pursuant to [section 41-4711, Idaho Code](#).

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health benefit plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

(a) The deductible/limit year used under the plan;

(b) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(c) If the plan does not impose deductibles or limits on a yearly basis or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(d) In any other case, the plan year is the calendar year.

(21) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(22) "Program" means the Idaho small employer [health] reinsurance program created in [section 41-4711, Idaho Code](#).

(23) “Qualifying previous coverage” and “qualifying existing coverage” mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool or any other similar publicly sponsored program; or

(b) Any other group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a health maintenance organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(24) “Rating period” means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(25) “Reinsuring carrier” means a small employer carrier participating in the reinsurance program pursuant to [section 41-4711, Idaho Code](#).

(26) “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(27) “Risk-assuming carrier” means a small employer carrier whose application is approved by the director pursuant to [section 41-4710, Idaho Code](#).

(28) “Small employer” means any person, firm, corporation, partnership or association that is actively engaged in business that employed an average of at least two (2) but no more than fifty (50) eligible employees on business days during the preceding calendar year and that employs at least two (2) but no more than fifty (50) eligible employees on the first day of the plan year, the majority of whom were and are employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

(29) “Small employer basic health benefit plan” means a lower cost health benefit plan developed pursuant to [section 41-4712, Idaho Code](#).

(30) “Small employer carrier” means a carrier that offers health benefit plans covering eligible employees of one (1) or more small employers in this state.

(31) “Small employer catastrophic health benefit plan” means a higher limit health benefit plan developed pursuant to [section 41-4712, Idaho Code](#).

(32) “Small employer standard health benefit plan” means a health benefit plan developed pursuant to [section 41-4712, Idaho Code](#).

History.

[I.C., § 41-4703](#), as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 2, p. 1337; am. 1995, ch. 360, § 2, p. 1235; am. 1997, ch. 321, § 12, p. 948; am. 1998, ch. 143, § 1, p. 507; am. 2000, ch. 472, § 2, p. 1602; am. 2001, ch. 296, § 8, p. 1044; am. 2003, ch. 267, § 1, p. 706; am. 2007, ch. 148, § 2, p. 427; am. 2009, ch. 125, § 8, p. 391; am. 2013, ch. 266, § 13, p. 652.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 148, updated the section reference in subsection (3); and in subsection (11), substituted “twenty-one (21) years” for “nineteen (19) years” and “twenty-five (25) years” for “twenty-three (23) years.”

The 2009 amendment, by ch. 125, rewrote subsection (11) and substituted “the plan year is” for “the year plan is” in the introductory language in subsection (20).

The 2013 amendment, by ch. 266, updated the reference in subsection (10) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

Federal References.

For civilian health and medical program for uniformed services (CHAMPUS), referred to in paragraph (23)(a), see [10 USCS § 1071 et seq.](#)

For Indian health service program, referred to in paragraph (23)(a), see [25 USCS § 1665a](#).

Compiler's Notes.

For American academy of actuaries, referred to in subsection (1), see <http://www.actuary.org>.

The bracketed insertions in subsections (5) and (22) were added by the compiler to reflect the correct, full name of the program created in § 41-4711.

Effective Dates.

Section 19 of S.L. 2000, ch. 472 provides: “This act shall be in full force and effect on and after July 1, 2000; provided however, that the basic, standard, catastrophic A and catastrophic B health benefit plans provided for in Section 2 of this act shall not be available until January 1, 2001”.

Section 5 of S.L. 2003, ch. 267 declared an emergency. Approved April 8, 2003.

§ 41-4704. Applicability and scope. — With the exception of a health benefit plan subject to regulation under chapter 52, title 41, Idaho Code, and to the extent permitted by federal law, the provisions of this chapter shall apply to any health benefit plan delivered or issued for delivery in the state of Idaho that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, section 125 or section 106 of the United States internal revenue code.

(4)(a) Except as provided in subsection (b) of this section [paragraph (b) of this subsection], for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one (1) carrier and any restrictions or limitations imposed in this chapter shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one (1) carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of authority pursuant to the provisions of chapter 39, title 41, Idaho Code, may be considered to be a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the director, a small employer carrier shall not enter into one (1) or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of sections 41-510

and 41-511, Idaho Code, shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one (1) or more health benefit plans delivered or issued for delivery to small employers in this state.

History.

I.C., § 41-4704, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 3, p. 1337; am. 1995, ch. 360, § 3, p. 1235.

STATUTORY NOTES

Federal References.

Sections 106, 125, and 162 of the Internal Revenue Code, referred to in subsection (3), are compiled as 26 U.S.C.S. §§ 106, 125, and 162, respectively.

Compiler's Notes.

The bracketed insertion in subsection (3) was added by the compiler to clarify the statutory reference.

§ 41-4705. Establishment of classes of business. — (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

- (a) The small employer carrier uses more than one (1) type of system for the marketing and sale of health benefit plans to small employers;
- (b) The small employer carrier has acquired a class of business from another small employer carrier; or
- (c) The small employer carrier provides coverage to one (1) or more association groups that meet the requirements of [section 41-2202, Idaho Code](#).

(2) A small employer carrier may establish up to nine (9) separate classes of business under the provisions of subsection (1) of this section.

(3) The director may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with the provisions of subsection (2) of this section in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that such action would enhance the efficiency and fairness of the small employer marketplace.

History.

[I.C., § 41-4705](#), as added by 1993, ch. 176, § 1, p. 435.

STATUTORY NOTES

Effective Dates.

Section 3 of S.L. 1993, ch. 176 read: “The provisions of this chapter shall be effective July 1, 1993. A small employer carrier shall not be required to

comply with the provisions of sections 41-4705, 41-4706, and 41-4707, Idaho Code, until January 1, 1994.”

§ 41-4706. Restrictions relating to premium rates. — (1) Premium rates for health benefit plans subject to the provisions of this chapter shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to [section 41-4711, Idaho Code](#), or chapter 55, title 41, Idaho Code.

(f)(i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(h) The small employer carrier shall not use case characteristics, other than age, individual tobacco use, geography, as defined by rule of the director, or gender, without prior approval of the director.

(i) A small employer carrier may utilize age as a case characteristic in establishing premium rates, provided that the same rating factor shall be applied to all dependents under twenty-five (25) years of age, and the same rating factor may be applied on an annual basis as to individuals or nondependents twenty (20) years of age or older.

(j) The director may establish rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including rules that:

(i) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;

(ii) Prescribe the manner in which case characteristics may be used by small employer carriers; and

(iii) Prescribe the manner in which a small employer carrier is to demonstrate compliance with the provisions of this section, including requirements that a small employer carrier provide the director with actuarial certification as to such compliance.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

(3) The director may suspend for a specified period the application of subsection (1)(a) of this section as to the premium rates applicable to one (1) or more small employers included within a class of business of a small employer carrier for one (1) or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other

than claim experience, that affect changes in premium rates;

(c) The provisions relating to renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(5)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with the provisions of this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (4)(a) of this section available to the director upon request. Except in cases of violations of the provisions of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

History.

I.C., § 41-4706, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 4, p. 1337; am. 1995, ch. 360, § 4, p. 1235; am. 1997, ch. 232, § 1, p. 675; am. 2000, ch. 415, § 1, p. 1321; am. 2000, ch. 472, § 3, p. 1602; am. 2002, ch. 99, § 1, p. 269; am. 2004, ch. 360, § 1, p. 1076; am. 2007, ch. 148, § 3, p. 427.

STATUTORY NOTES

Amendments.

This section was amended by two 2000 acts which appear to be compatible and have been compiled together.

The 2000 amendment, by ch. 415, § 1, in subsection (1), deleted “provisions of the” following “shall be subject to the”; in subsection (1)(j), deleted “the age of” following “dependents under”, inserted “years of age” following “twenty-three (23)”, substituted “may be applied on an annual basis” for “shall be applied on a quinquennial basis”.

The 2000 amendment, by ch. 472, § 3, in subsection (1), deleted “the provisions of” following “shall be subject to”, at the end of the first sentence in subsection (1)(b), substituted “fifty percent (50%)” for “twenty-five (25%)”, and added the last sentence, added at the end of subsection (1)(e), “, or chapter 55, title 41, Idaho Code”, deleted former subsection (1)(f); redesignated former subsections (1)(g) through (1)(k) as present subsections (1)(f) through (1)(j); in present subsection (1)(i), substituted “under twenty-three (23) years of age” for “under the age of twenty-three (23)”.

The 2007 amendment, by ch. 148, substituted “twenty-five (25) years” for “twenty-three (23) years” in subsection (1)(i).

Effective Dates.

Section 3 of S.L. 1993, ch. 176 read: “The provisions of this chapter shall be effective July 1, 1993. A small employer carrier shall not be required to comply with the provisions of sections 41-4705, 41-4706, and 41-4707, Idaho Code, until January 1, 1994.”

§ 41-4707. Renewability of coverage. — (1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

- (a) Nonpayment of the required premiums;
- (b) Fraud or intentional misrepresentation of material fact by the small employer;
- (c) Noncompliance with the carrier's minimum participation requirements;
- (d) Noncompliance with the carrier's employer contribution requirements;
- (e) In the case of health benefit plans that are made available in the small employer market only through one (1) or more associations as defined in [section 41-2202, Idaho Code](#), the membership of an employer in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual;
- (f) The small employer no longer meets the requirements of [section 41-4703\(28\), Idaho Code](#);
- (g) The small employer carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to small employers in this state. Unless otherwise authorized in advance by the department of insurance, a carrier may discontinue a product only after the product has been in use for at least thirty-six (36) consecutive months, provided the carrier may not discontinue more than fifteen percent (15%) of its total number of employees and dependents in all lines of business regulated by this chapter in a twelve (12) month period. The carrier shall:
 - (i) Provide advance written or electronic notice of its decision under this paragraph to the director;

- (ii) Provide notice of the discontinuation to all affected employers and employees or dependents at least ninety (90) calendar days prior to the date the particular health benefit plan will be discontinued by the carrier, provided that notice to the director under the provisions of this paragraph shall be provided at least fourteen (14) calendar days prior to the notice to the affected employers;
 - (iii) Offer to each affected employer, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the carrier to small employers in this state;
 - (iv) In exercising the option to discontinue the health benefit plan and in offering the option to purchase all other health benefit plans under the provisions of this paragraph, act uniformly without regard to:
 - 1. The claims experience of an affected employer;
 - 2. Any health status-related factor relating to any affected employee or dependent; or
 - 3. Any health status-related factor relating to any new employee or dependent who may become eligible for the coverage; and
 - (v) Offer the new products at rates that comply with [section 41-4706\(1\)\(c\), Idaho Code](#).
- (h) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:
- (i) Provide advance notice of its decision under this paragraph to the director in each state in which it is licensed; and
 - (ii) Provide notice of the decision not to renew coverage to all affected small employers and to the director at least one hundred eighty (180) calendar days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected small employers; or
- (i) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the director shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(h) of this section shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the director.

(3) In the case of a small employer carrier doing business in one (1) established geographic service area of the state, the rules set forth in this subsection [section] shall apply only to the carrier's operations in that service area.

History.

I.C., § 41-4707, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 5, p. 1337; am. 1995, ch. 360, § 12, p. 1235; am. 1997, ch. 321, § 13, p. 948; am. 1998, ch. 143, § 2, p. 507; am. 2000, ch. 472, § 4, p. 1602; am. 2006, ch. 353, § 2, p. 1079.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 353, added paragraph (1)(g).

Compiler's Notes.

The bracketed insertion in subsection (3) was added by the compiler to supply the probable intended term.

Effective Dates.

Section 3 of S.L. 1993, ch. 176 read: "The provisions of this chapter shall be effective July 1, 1993. A small employer carrier shall not be required to comply with the provisions of sections 41-4705, 41-4706, and 41-4707, Idaho Code, until January 1, 1994."

§ 41-4708. Availability of coverage — Preexisting conditions — Portability. — (1) Every small employer carrier shall, as a condition of offering health benefit plans in this state to small employers, actively offer to small employers all benefit plans, including the small employer basic health benefit plan, the small employer standard health benefit plan, and the small employer catastrophic health benefit plan.

(2)(a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the small employer basic, standard and catastrophic health benefit plans to be used by the carrier. A health benefit plan filed pursuant to the provisions of this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic, standard or catastrophic health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(3) Health benefit plans covering small employers shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(b) Genetic information shall not be considered as a condition described in this subsection in the absence of a diagnosis of the condition related to such information.

(c) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to

particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This paragraph does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(d) A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan.

(e)(i) Except as provided in paragraph (e)(iv) of this subsection, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(f)(i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph (d) of this subsection.

(ii) A small employer carrier shall not modify a basic, standard or catastrophic health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4)(a) A small employer carrier shall not be required to offer coverage or accept applications pursuant to the provisions of subsection (1) of this section in the case of the following:

(i) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(ii) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

(iii) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier that cannot offer coverage pursuant to the provisions of subsection (4)(a)(iii) of this section may not offer coverage in the applicable area to new cases of employer groups with more than fifty (50) eligible employees or to any small employer groups until the later of one hundred eighty (180) days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

(5) A small employer carrier shall not be required to provide coverage to small employers pursuant to the provisions of subsection (1) of this section for any period of time for which the director determines that requiring the

acceptance of small employers in accordance with the provisions of subsection (1) of this section would place the small employer carrier in a financially impaired condition.

History.

I.C., § 41-4708, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 6, p. 1337; am. 1995, ch. 360, § 5, p. 1235; am. 1997, ch. 321, § 14, p. 948; am. 1998, ch. 143, § 3, p. 507; am. 2000, ch. 472, § 5, p. 1602.

Idaho Code § 41-4708A

§ 41-4708A. [Reserved.]

Idaho Code § 41-4708B

§ 41-4708B. Conversion plan — When required. — Any group carrier doing business in the state of Idaho that does not have an individual product on file with the department of insurance shall provide a conversion plan to all group insureds. The conversion plan shall provide benefits at least equal to the standard health benefit plan developed pursuant to [section 41-4712, Idaho Code](#). The premium under the plan shall not exceed one hundred twenty-five percent (125%) of the index rate for groups.

History.

[I.C., § 41-4708B](#), as added by 1996, ch. 124, § 2, p. 438.

§ 41-4709. Notice of intent to operate as a risk-assuming carrier or a reinsuring carrier. —

(1)(a) Each small employer carrier shall notify the director within thirty (30) days of the effective date of this chapter of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to the provisions of [section 41-4710, Idaho Code](#).

(b) The decision shall be binding for a five (5) year period except that the initial decision shall be binding for two (2) years. The director may permit a carrier to modify its decision at any time for good cause shown.

(c) The director shall establish an application process for small employer carriers seeking to change their status under the provisions of this subsection.

(2) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

History.

[I.C., § 41-4709](#), as added by 1993, ch. 176, § 1, p. 435.

STATUTORY NOTES

Compiler's Notes.

The phrase "the effective date of this chapter" in paragraph (1)(a) refers to the effective date of S.L. 1993, Chapter 176, which was effective July 1, 1993.

§ 41-4710. Application to become a risk-assuming carrier. — (1) A small employer carrier may apply to become a risk-assuming carrier by filing an application with the director in a form and manner prescribed by the director.

(2) The director shall consider the following factors in evaluating an application filed under the provisions of subsection (1) of this section:

- (a) The carrier's financial condition;
- (b) The carrier's history of rating and underwriting small employer groups;
- (c) The carrier's commitment to market fairly to all small employers in the state or its established geographic service area, as applicable;
- (d) The carrier's experience with managing the risk of small employer groups; and
- (e) The extent to which a carrier has and will be able to maintain reinsurance pursuant to the provisions of subsection (4)(c) of [section 41-4704, Idaho Code](#).

(3) The director shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty (60) day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the director, the carrier may request a hearing.

(4) The director may rescind the approval granted to a risk-assuming carrier under the provisions of this section if the director finds that:

- (a) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to small employers in compliance with the provisions of [section 41-4708, Idaho Code](#), without the protection afforded by the program;
- (b) The carrier has failed to market fairly to all small employers in the state or its established geographic service area, as applicable; or

(c) The carrier has failed to provide coverage to eligible small employers as required in [section 41-4708, Idaho Code](#).

(5) A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of [section 41-4711, Idaho Code](#), except to the extent such small employer carrier is subject to assessment for additional funding pursuant to the provisions of subsection (12)(c) of [section 41-4711, Idaho Code](#).

History.

[I.C., § 41-4710](#), as added by 1993, ch. 176, § 1, p. 435.

§ 41-4711. Small employer carrier [health] reinsurance program. —

(1) All carriers shall be subject to the provisions of this section.

(2) There is hereby created an independent public body corporate and politic to be known as the Idaho small employer health reinsurance program. The program will perform an essential governmental function in the exercise of powers conferred upon it in this act and any assessments imposed or collected pursuant to the operation of the program shall at all times be free from taxation of every kind.

(3) The program shall operate subject to the supervision and control of the board established in [section 41-5502, Idaho Code](#).

(4) Each carrier shall make a filing with the director containing the carrier's earned health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

(5) The board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the director.

(6) If the board fails to submit a suitable plan of operation, the director shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The director shall approve the plan of operation submitted by the board, or adopt a temporary plan of operation if the board fails to submit a suitable plan. The director shall amend or rescind any plan adopted under the provisions of this subsection at the time a plan of operation is submitted by the board and approved by the director.

(7) The plan of operation shall:

- (a) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the director;
- (b) Establish procedures for selecting an administrator, which shall be properly licensed in this state, and setting forth the powers and duties of the administrator;
- (c) Establish procedures for reinsuring risks in accordance with the provisions of this section;
- (d) Establish procedures for collecting assessments from carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and
- (e) Provide for any additional matters necessary for the implementation and administration of the program.

(8) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

- (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the director, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
- (b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any carrier;
- (c) Take any legal action necessary to avoid the payment of improper claims against the program;
- (d) Define the health benefit plans, which plans shall allow coordination of benefits, for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this chapter;
- (e) Establish rules, conditions and procedures for reinsuring risks under the program, including broad discretion to operate the small employer

[health] reinsurance program;

(f) Establish actuarial functions as appropriate for the operation of the program;

(g) Assess carriers in accordance with the provisions of subsection (12) of this section, and to make advance interim assessments of carriers as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;

(i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(9) A carrier may reinsure with the program as provided for in this subsection:

(a) With respect to a small employer basic, standard or catastrophic health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a small employer basic, standard or catastrophic health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.

(c) A small employer carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his coverage. Newborn dependents of insureds are not eligible for reinsurance unless a parent is already reinsured.

(d)(i) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars (\$5,000) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next fifty thousand dollars (\$50,000) of benefit payments during a calendar year and the program shall reinsure the remainder.

(ii) The board annually may adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the department of labor, bureau of labor statistics, unless the board proposes and the director approves a lower adjustment factor.

(e) A reinsuring carrier may terminate reinsurance with the program for one (1) or more of the reinsured employees or dependents on any anniversary of the health benefit plan.

(f) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(10)(a) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit

plan, adjusted to reflect retention levels required under the provisions of this chapter.

(b) Premiums for the program shall be as established by the board.

(c) The board periodically shall review the methodology established under the provisions of paragraph (10)(a) of this section, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(11) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in [section 41-4706, Idaho Code](#).

(12)(a) Prior to March 1 of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of carriers.

(c)(i) For the assessment of March 1, 1995, and prior to March 1 of each succeeding year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(ii) The assessments shall be determined by multiplying net losses, if net earnings are negative, as defined by subsection (12)(a) of this section, by a fraction, the numerator of which shall be the carrier's total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease, and hospital confinement indemnity in this state as reported in the carrier's annual report pursuant to subsection (16) of this section, and the denominator of which shall be the total premiums earned in the preceding calendar year from all health benefit plans and policies or

certificates of insurance for specific disease and hospital confinement indemnity in this state.

(d) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

(e) Each carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carriers with the board or with the director.

(f) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(g) A carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a carrier if the director determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this subsection. The carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any groups with the program until such time as it pays the assessments.

(13)(a) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required under the provisions of this chapter shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

(b) Neither the board nor its employees shall be liable for any obligations of the program. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. The board may provide for indemnification of, and legal representation for, its members and employees.

(14) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of small employer basic, standard and catastrophic health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

(15) The program shall be exempt from any and all taxes.

(16) Each carrier shall file with the director, in a form and manner to be prescribed by the director, an annual report. The report shall state the number of resident persons insured under the carrier's health benefit plan.

(17) If a reinsuring small employer carrier attempts to reinsure or reinsures an entire employer group, an employee, or a dependent of such employee that, immediately prior to the commencement of such coverage, it covered under a health benefit plan, the board shall assess all costs and losses incurred by the program for claims and administrative expenses relating to such group, employee or dependent of such employee only to the said reinsuring small employer carrier.

(18) Subsection (17) of this section shall apply to assessments made for the 1994 calendar year and each year thereafter.

History.

I.C., § 41-4711, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 7, p. 1337; am. 1995, ch. 360, § 6, p. 1235; am. 1997, ch. 321, § 15, p. 948; am. 2000, ch. 472, § 6, p. 1602; am. 2002, ch. 197, § 1, p. 557; am. 2003, ch. 267, § 2, p. 706.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertions in the section heading and paragraph (8)(e) were added by the compiler to reflect the actual name of the program created in the text of this section.

For Consumer Price Index for All Urban Consumers, referenced in paragraph (9)(d)(ii), see *<http://www.bls.gov/news.release/cpi.t01.htm>*.

Effective Dates.

Section 16 of S.L. 1995, ch. 360, declared an emergency and provided that subsection (2) of this section as amended in § 6 of the act should be in full force and effect retroactive to July 1, 1993. Approved March 22, 1995.

Section 2 of S.L. 2002, ch. 197 declared an emergency. Approved March 21, 2002.

Section 5 of S.L. 2003, ch. 267 declared an emergency. Approved April 8, 2003.

§ 41-4712. Small employer health benefit plans. — (1) The board, in addition to its other powers and duties, shall establish the form and level of coverages, including benefit levels, cost-sharing levels, exclusions and limitations for the small employer basic, standard and catastrophic health benefit plans to be made available by small employer carriers pursuant to [section 41-4708, Idaho Code](#), with an emphasis on making coverage available for preventive care.

(2) The board shall also design a small employer basic, standard and catastrophic health benefit plan which each contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of managed care organizations, including any restrictions imposed by federal law. The plans or changes established by the board may include cost containment features such as:

- (a) Utilization review of health care services, including review of medical necessity of hospital and physician services;
- (b) Case management;
- (c) Selective contracting with hospitals, physicians and other health care providers;
- (d) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and
- (e) Other managed care provisions.

(3) The board shall submit the plans or changes approved by the board to the director for approval not later than March 1 of each year. The director shall promulgate the approved plans pursuant to the provisions of [section 41-4715, Idaho Code](#).

(4) Small employer carriers desiring to issue a small employer basic, standard or catastrophic health benefit plan differing from the form and level of coverage approved by the board and the director shall submit such plan to the board for review to insure that such proposed plan is commensurate with the benefit levels, cost-sharing levels, exclusions, and

limitations for the plan developed and approved pursuant to the provisions of this section.

(5) The board may appoint an advisory committee to assist in the development of and any changes to the small employer basic, standard and catastrophic health benefit plans.

History.

I.C., § 41-4712, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 8, p. 1337; am. 1995, ch. 360, § 7, p. 1235; am. 1997, ch. 321, § 16, p. 948; am. 2000, ch. 472, § 7, p. 1602.

§ 41-4713. Periodic market evaluation. — The board, in consultation with members of the committee, shall study and report at least every three (3) years to the director on the effectiveness of chapters 47 and 52, title 41, Idaho Code. The report shall analyze the effectiveness of the chapters in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group and individual health insurance marketplace. The report shall address whether carriers and agents are fairly and actively marketing or issuing health benefit plans to small employers and individuals in fulfillment of the purposes of the chapters. The report may contain recommendations for market conduct or other regulatory standards or action.

History.

I.C., § 41-4713, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 9, p. 1337.

§ 41-4714. Waiver of certain state laws. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-4714, as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 10, p. 1337; am. 1997, ch. 321, § 17, p. 948, was repealed by S.L. 2000, ch. 472, § 9, effective July 1, 2000.

§ 41-4715. Administrative procedures. — The director shall promulgate rules and regulations in accordance with the provisions of chapter 52, title 67, Idaho Code, for the implementation and administration of the small employer health coverage reform act.

History.

I.C., § 41-4715, as added by 1993, ch. 176, § 1, p. 435.

STATUTORY NOTES

Compiler's Notes.

The small employer health coverage reform act is codified as this chapter, chapter 47, title 41, Idaho Code.

§ 41-4716. Standards to assure fair marketing. — (1) Each small employer carrier shall actively market health benefit plan coverage, including the small employer basic, standard and catastrophic health benefit plans, to eligible small employers in the state.

(2)(a) Except as provided in subsection (2)(b) of this section, no small employer carrier or agent shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(ii) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(b) The provisions of subsection (2)(a) of this section shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3)(a) Except as provided in subsection (2)(b) of this section, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(b) The provisions of subsection [paragraph] (a) of this [sub]section shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for

the sale of a small employer basic, standard or catastrophic health benefit plan.

(5) No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation or geographic location of the small employers placed by the agent with the small employer carrier.

(6) No small employer carrier or agent may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(8) The director may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9)(a) A violation of the provisions of this section by a small employer carrier or an agent shall be an unfair trade practice pursuant to the provisions of [section 41-1302, Idaho Code](#).

(b) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to the provisions of this section as if it were a small employer carrier.

History.

[I.C., § 41-4716](#), as added by 1993, ch. 176, § 1, p. 435; am. 1994, ch. 427, § 11, p. 1337; am. 1997, ch. 321, § 18, p. 948; am. 2000, ch. 472, § 8, p. 1602.

STATUTORY NOTES

Compiler's Notes.

The bracketed language in paragraph (3)(b) was inserted by the compiler to clarify the reference.

Section 2 of S.L. 1993, ch. 176 read: “The provisions of this chapter are hereby declared to be severable and if any provision of this chapter or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this chapter.”

Section 12 of S.L. 1994, ch. 427 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this chapter or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this chapter.”

Effective Dates.

Section 3 of S.L. 1993, ch. 176 read: “The provisions of this chapter shall be effective July 1, 1993. A small employer carrier shall not be required to comply with the provisions of sections 41-4705, 41-4706, and 41-4707, Idaho Code, until January 1, 1994.”

Section 13 of S.L. 1994, ch. 427 provided: “Effective Date. The provisions of this act shall be effective July 1, 1994. An individual carrier shall not be required to comply with the provisions of sections 41-5205, 41-5206 and 41-5207, Idaho Code, until January 1, 1995.”

**§ 41-4717. Health insurance coverage for dependent children.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

This section, which comprised (I.C., § 41-4717, as added by 1994, ch. 365, § 12, p. 1144; am. 1998, ch. 292, § 27, p. 928) was repealed by S.L. 2003, ch. 304, § 1, effective July 1, 2003.

§ 41-4718. Catastrophic plans.[Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-4718, as added by 1995, ch. 360, § 14, p. 1235, was repealed by S.L. 2000, ch. 472, § 9, effective July 1, 2000.

Chapter 48

RISK RETENTION GROUPS

Sec.

41-4801. Short title.

41-4802. Purpose.

41-4803. Definitions.

41-4804. Risk retention groups chartered in this state.

41-4805. Risk retention groups not chartered in this state.

41-4806. Compulsory associations.

41-4807. Counter signatures not required.

41-4808. Purchasing groups — Exemption from certain laws relating to the group purchase of insurance.

41-4809. Notice and registration requirements of purchasing groups.

41-4810. Restrictions on insurance purchased by purchasing groups.

41-4811. Administrative and procedural authority regarding risk retention groups and purchasing groups.

41-4812. Penalties.

41-4813. Duty of agents or brokers to obtain license.

41-4814. Binding effect of orders issued in U.S. district courts.

41-4815. Rules and regulations.

41-4816. Purchasing group taxation.

Idaho Code § 41-4801

§ 41-4801. Short title. — This chapter may be cited as the “Idaho Liability Risk Retention Act.”

History.

I.C., 41-4801, as added by 1987, ch. 140, § 1, p. 274.

§ 41-4802. Purpose. — The purpose of this chapter is to regulate the formation and operation of risk retention groups in Idaho formed pursuant to the provisions of the federal liability risk retention act of 1986.

History.

I.C., 41-4802, as added by 1987, ch. 140, § 1, p. 274.

STATUTORY NOTES

Federal References.

The federal liability risk retention act of 1986, referred to in this section, is compiled as 15 U.S.C.S. §§ 3901 to 3903, 3905, 3906 and 42 U.S.C.S. §§ 9671 to 9675.

§ 41-4803. Definitions. — As used in this chapter:

(1) “Director” means the director of the department of insurance of this state or the director, commissioner, or superintendent of the department of insurance of any other state.

(2) “Completed operations liability” means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by:

(a) Any person who performs that work; or

(b) Any person who hires an independent contractor to perform that work, but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(3) “Domicile” for purposes of determining the state in which a purchasing group is domiciled means:

(a) For a corporation, the state in which the purchasing groups [group] is incorporated; or

(b) For an unincorporated entity, the state of its principal place of business.

(4) “Hazardous financial condition” means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

(a) To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(b) To pay other obligations in the normal course of business.

(5) “Insurance” means primary insurance, excess insurance, reinsurance, surplus lines insurance, or any other arrangement for shifting and distributing risk which is determined to be insurance under this code.

(6) “Liability” means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses because of injuries to other persons, damage to their property, or other damage or loss to such

other persons resulting from or arising out of any business whether profit or nonprofit, trade, product, services including professional services, premises, or operations, or arising out of any activity of any state or local government, or any agency or political subdivision thereof, but does not include personal risk liability or with the exception of an employer's legal liability with respect to its employees under the federal employers' liability act ([45 U.S.C. 51 et seq.](#)), an employer's liability.

(7) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any person [personal], familial, or household responsibilities or activities apart from responsibilities or activities referred to in subsection (6) of this section.

(8) "Plan of operation or feasibility study" means an analysis which presents the expected activities and results of a risk retention group, including, at a minimum:

- (a) The coverages, deductibles, coverage limits and rates and rating classifications systems for each line of insurance the group would offer;
- (b) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;
- (c) Pro forma financial statements and projections;
- (d) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent hazardous financial conditions;
- (e) Identification of management, underwriting procedures and guidelines, managerial oversight methods, and investment policies; and
- (f) Such other items as may be required by the director for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered.

(9) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage (including damages resulting from the loss of use of

property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

(10) “Purchasing group” means any group which:

(a) Has as one of its purposes the purchase of liability insurance on a group basis;

(b) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph (c) of this subsection;

(c) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(d) Is domiciled in any state.

(11) “Risk retention group” means any corporation or other limited liability association:

(a) Whose primary activity consists of assuming and spreading all, or any portion of the liability exposure of its group members;

(b) Which is organized for the primary purpose of conducting the activity described under paragraph (a) of this subsection which:

(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance director of at least one (1) state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in such business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or

completed operations liability, as such terms were defined in the federal product liability risk retention act of 1981 before the date of the enactment of the federal liability risk retention act of 1986;

(c) Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person which:

(i) Has as its members only persons who have an ownership interest in the group and which has as its owners only persons who are members who are provided insurance by the risk retention group; or

(ii) Has as its sole member and sole owner an organization which is owned by persons who are provided insurance by the risk retention group;

(d) Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations; or

(e) Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) Reinsurance with respect to the liability of any other risk retention group or any members of such other group, which is engaged in businesses or activities so that such group or member meets the requirement described in paragraph (d) of this subsection from membership in the risk retention group which provides such reinsurance;

(f) The name of which includes the phrase “risk retention group”.

(12) “State” means any state of the United States or the District of Columbia.

History.

I.C., 41-4803, as added by 1987, ch. 140, § 1, p. 274.

STATUTORY NOTES

Federal References.

The federal product liability risk retention act of 1981, referred to in paragraph (11)(b)(ii), is Act of Sept. 25, 1981, **P.L. 97-45**, which is codified as **15 USCS §§ 3901 to 3906**.

The federal liability risk retention act of 1986, referred to in paragraph (11)(b)(ii), is compiled as **15 U.S.C.S. §§ 3901 to 3903, 3905, 3906** and **42 U.S.C.S. §§ 9671 to 9675**.

Compiler's Notes.

The bracketed insertions in paragraph (3)(a) and in subsection (7) were added by the compiler to correct the enacting legislation.

The words in parentheses so appeared in the law as enacted.

§ 41-4804. Risk retention groups chartered in this state. — (1) A risk retention group seeking to be chartered in this state must be chartered and licensed as a liability insurance company authorized by the insurance laws of this state and, except as provided elsewhere in this chapter, must comply with:

- (a) All of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this state;
- (b) [Section 41-4805, Idaho Code](#), to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state.

(2) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the director of this state a plan of operation or feasibility study and revisions of such plan or study if the group intends to offer any additional lines of liability insurance. Immediately upon receipt of an application for charter, this state shall provide:

- (a) Summary information concerning the filing to the national association of insurance commissioners, including the name of the risk retention group, the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group;
- (b) The amount and nature of initial capitalization;
- (c) The coverages to be afforded; and
- (d) The states in which the group intends to operate.

Providing notification to the national association of insurance commissioners is in addition to and shall not be sufficient to satisfy the requirements of [section 41-4805, Idaho Code](#), or any other sections of this chapter.

History.

[I.C., § 41-4804](#), as added by 1987, ch. 140, § 1, p. 274.

STATUTORY NOTES

Compiler's Notes.

As to national association of insurance commissioners, referred to in paragraphs (2)(a) and in the last paragraph in subsection (2), see *<http://naic.org>*.

§ 41-4805. Risk retention groups not chartered in this state. — Risk retention groups chartered in states other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as follows:

(1) Before transacting any insurance business or offering any insurance policies in this state, a risk retention group shall submit to the director of this state:

(a) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, the date of chartering, the risk retention group's principal place of business, and such other information including information concerning its membership as the director of this state may require to verify that the risk retention group is qualified as defined in subsection (11) of [section 41-4803, Idaho Code](#);

(b) A copy of its plan of operations or feasibility study and revisions of such plan or study submitted to its state of domicile; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which was defined in the product liability risk retention act of 1981 before October 27, 1986, and was offered before such date by any risk retention group which had been chartered and operating for not less than three (3) years before such date;

(c) A statement of registration which designates the director as its agent for the purpose of receiving service of legal documents or process against the risk retention group.

(2) Any risk retention group doing business in this state shall submit the following financial information to the director:

(a) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American academy of actuaries or a

qualified loss reserve specialist operating under criteria established by the national association of insurance commissioners;

(b) A copy of each examination of the risk retention group as certified by the director or public official conducting the examination;

(c) Upon request by the director, a copy of any audit performed with respect to the risk retention group; and

(d) Such information as may be required to verify the group's continuing qualification as a risk retention group as defined in subsection (11) of [section 41-4803, Idaho Code](#).

(3) All risk retention groups operating in this state, and all premiums paid for any coverage within this state to any risk retention group, shall be subject to the same premium tax provisions, including any interest, fines, and penalties for nonpayment, as are applicable to foreign admitted insurers. To the extent any agents or brokers are utilized, they shall report and pay the taxes for the premiums for risks which they have placed with or on behalf of any risk retention group not chartered in this state. To the extent any agents or brokers are not utilized, or agents or brokers that are utilized fail to pay said premium tax, each risk retention group shall pay the tax for risks insured within the state. Further, each risk retention group shall report to the director all premiums paid to it for risks insured within this state.

(4) Any risk retention groups and its agents and representatives are subject to and shall comply with the provisions of [section 41-1329, Idaho Code](#) (unfair claim settlement practices).

(5) Any risk retention group formed in this state shall comply with and be subject to chapter 13, title 41, Idaho Code (trade practices and frauds). The director may issue orders enjoining prohibited practices in accordance with [section 41-213, Idaho Code](#), or [section 41-1321, Idaho Code](#), or may apply directly to the district court for Ada county, state of Idaho, for such injunctive relief as he deems appropriate.

(6) Any risk retention group must submit to an examination by the director of this state to allow him to determine the group's financial condition if the director of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within

sixty (60) days after a request by the director of this state. Any such examination shall be coordinated to avoid unjustified repetition or duplication and shall be conducted in an expeditious manner.

(7) Any policy issued by a risk retention group shall contain in 10 point or larger type on the front page and the declaration page, the following notice:

NOTICE

This policy has been issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(8) In addition to other restrictions that may be applicable, the following acts by a risk retention group are hereby prohibited:

(a) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

(b) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

(9) No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group whose members are all insurance companies.

(10) No risk retention group may offer any insurance policy or insurance coverage that has been declared unlawful by the Idaho supreme court or is in conflict with chapter 5 or chapter 25, title 41, Idaho Code.

(11) A risk retention group not chartered in this state and doing business in this state must comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by another state's insurance director if there has been a finding of financial impairment after an examination pursuant to subsection (6) of this section.

History.

I.C., § 41-4805, as added by 1987, ch. 140, § 1, p. 274; am. 2005, ch. 78, § 5, p. 78.

STATUTORY NOTES

Federal References.

The federal product liability risk retention act of 1981, referred to in paragraph (1)(b), is Act of Sept. 25, 1981, P.L. 97-45, which is codified as 15 USCS §§ 3901 to 3906.

Compiler's Notes.

For American academy of actuaries, referred to in paragraph (2)(a), see <http://www.actuary.org>.

As to national association of insurance commissioners, referred to in paragraph (2)(a), see <http://naic.org>.

The words in parentheses so appeared in the law as enacted.

RESEARCH REFERENCES

A.L.R. — Construction and Application of Federal Product Liability Risk Retention Act of 1981, and Amending Liability Risk Retention Act of 1996, 15 U.S.C. § 3901 et seq. 11 A.L.R. Fed. 3d 3.

§ 41-4806. Compulsory associations. — No risk retention group shall be permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state, nor shall any risk retention group, or its insureds, receive any benefit from any such fund for claims arising out of the operations of such risk retention group.

History.

I.C., § 41-4806, as added by 1987, ch. 140, § 1, p. 274.

§ 41-4807. Counter signatures not required. — A policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned as otherwise provided in sections 41-337 and 41-338, Idaho Code.

History.

I.C., § 41-4807, as added by 1987, ch. 140, § 1, p. 274; am. 2005, ch. 75, § 3, p. 254.

§ 41-4808. Purchasing groups — Exemption from certain laws relating to the group purchase of insurance. — Any purchasing group meeting the criteria established under the provisions of the federal liability risk retention act of 1986 shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that would discriminate against a purchasing group or its members. In addition, an insurer shall be exempt from any law of this state which prohibits providing, or offering to provide to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters. A purchasing group shall be subject to all other applicable laws of this state.

History.

I.C., § 41-4808, as added by 1987, ch. 140, § 1, p. 274.

STATUTORY NOTES

Federal References.

The federal liability risk retention act of 1986, referred to in this section, is compiled as 15 U.S.C.S. §§ 3901 to 3903, 3905, 3906 and 42 U.S.C.S. §§ 9671 to 9675.

§ 41-4809. Notice and registration requirements of purchasing groups. — (1) A purchasing group which intends to do business in this state shall furnish notice to the director which shall:

- (a) Identify the state in which the group is domiciled;
- (b) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;
- (c) Identify the insurance company from which the group intends to purchase its insurance and the domicile of such company;
- (d) Identify the principal place of business of the group; and
- (e) Provide such other information as may be required by the director to verify that the purchasing group is qualified as defined in subsection (10) of [section 41-4803, Idaho Code](#).

(2) The purchasing group shall register with and designate the director as its agent for the purpose of receiving service of legal documents or process, except that such requirements shall not apply in the case of a purchasing group:

- (a) Which was domiciled before April 1, 1986, and is domiciled on and after October 27, 1986, in any state of the United States;
- (b) Which before October 27, 1986, purchased insurance from an insurance carrier licensed in any state and since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state;
- (c) Which was a purchasing group under the requirements of the product liability risk retention act of 1981 before October 27, 1986; and
- (d) Which does not purchase insurance that was not authorized for purposes of an exemption under that act, as in effect before October 27, 1986.

History.

[I.C., § 41-4809](#), as added by 1987, ch. 140, § 1, p. 274.

STATUTORY NOTES

Federal References.

The federal product liability risk retention act of 1981, referred to in paragraph (2)(c), is Act of Sept. 25, 1981, [P.L. 97-45](#), which is codified as [15 USCS §§ 3901 to 3906](#).

RESEARCH REFERENCES

A.L.R. — Construction and Application of Federal Product Liability Risk Retention Act of 1981, and Amending Liability Risk Retention Act of 1996, [15 U.S.C. § 3901 et seq.](#) 11 [A.L.R. Fed.](#) 3d 3.

§ 41-4810. Restrictions on insurance purchased by purchasing groups. — A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state, nor from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

History.

I.C., § 41-4810, as added by 1987, ch. 140, § 1, p. 274.

§ 41-4811. Administrative and procedural authority regarding risk retention groups and purchasing groups. — The director is authorized to make use of any of the powers established under this code to enforce the laws of this state so long as those powers are not specifically preempted by the product liability risk retention act of 1981, as amended by the risk retention amendments of 1986. This includes, but is not limited to, the director's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders and impose penalties. With regard to any investigation, administrative proceedings, or litigation, the director may rely on the procedural law and regulations of the state. The injunctive authority of the director in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

History.

I.C., § 41-4811, as added by 1987, ch. 140, § 1, p. 274.

STATUTORY NOTES

Federal References.

The federal product liability risk retention act of 1981, referred to in this section, is Act of Sept. 25, 1981, P.L. 97-45, which is codified as 15 USCS §§ 3901 to 3906.

The federal liability risk retention act of 1986, referred to in this section, is compiled as 15 U.S.C.S. §§ 3901 to 3903, 3905, 3906 and 42 U.S.C.S. §§ 9671 to 9675.

RESEARCH REFERENCES

A.L.R. — Construction and Application of Federal Product Liability Risk Retention Act of 1981, and Amending Liability Risk Retention Act of 1996, 15 U.S.C. § 3901 et seq. 11 A.L.R. Fed. 3d 3.

§ 41-4812. Penalties. — A risk retention group which violates any provision of this chapter will be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license and/or the right to do business in this state.

History.

I.C., § 41-4812, as added by 1987, ch. 140, § 1, p. 274.

§ 41-4813. Duty of agents or brokers to obtain license. — Any person acting, or offering to act, as an agent or broker for a risk retention group or purchasing group, which solicits members, sells insurance coverage, purchases coverage for its members located within the state or otherwise does business in this state shall, before commencing any such activity, obtain a license from the director.

History.

I.C., § 41-4813, as added by 1987, ch. 140, § 1, p. 274.

§ 41-4814. Binding effect of orders issued in U.S. district courts. —
An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state, or in all states or in any territory or possession of the United States, upon a finding that such a group is in a hazardous financial condition shall be enforceable in the courts of the state.

History.

I.C., § 41-4814, as added by 1987, ch. 140, § 1, p. 274.

§ 41-4815. Rules and regulations. — The director may establish and from time to time amend such rules relating to risk retention groups as may be necessary or desirable to carry out the provisions of this chapter.

History.

I.C., § 41-4815, as added by 1987, ch. 140, § 1, p. 274.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 1987, ch. 140 declared an emergency. Approved March 27, 1987.

§ 41-4816. Purchasing group taxation. — Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing group shall be:

(1) Imposed at the same rate and subject to the same interest, fines and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

(2) Paid first by such insurance source, and if not by such source by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such purchasing group then by each of its members.

History.

I.C., § 41-4816, as added by 1990, ch. 348, § 1, p. 937.

Chapter 49

PETROLEUM CLEAN WATER TRUST FUND ACT

Sec.

41-4901. Short title.

41-4902. Legislative findings and intent.

41-4903. Definitions.

41-4904. Board of trustees of the fund.

41-4905. Creation, authorization and management of the Idaho petroleum clean water trust fund.

41-4906. Limits of liability for contracts of insurance issued by the administrator.

41-4907. Owner or operator financial responsibility.

41-4908. Exclusiveness of remedy.

41-4909. Source of trust fund — Application fees — Application for enrollment — Transfer fees.

41-4910. Distribution of application fees and transfer fees.

41-4910A. Apportionment of moneys transferred to the state highway account from the Idaho petroleum clean water trust fund suspense account on April 1, 1997.

41-4911. Issuance of contracts of insurance by the administrator of the Idaho petroleum clean water trust fund — Deferral.

41-4911A. Provisions of contracts of insurance — Renewal.

41-4912. Storage tanks eligible for insurance.

41-4912A. Storage tanks located on sites where contamination is present.

41-4913. State treasurer custodian of trust fund — Duties.

41-4914. Deposit and investment of funds — Interest.

41-4915. Perpetual appropriation.

41-4916. Enrolled subscribers' liability on judgment.

41-4917. Actions for collection in case of default — Penalty — Cancellation of insurance contract.

41-4918. Cancellation of insurance.

41-4919. Reinsurance.

41-4920. Payments from the trust fund by state treasurer.

41-4921. Reserve funds.

41-4922. Plan of operation.

41-4923. Registration of the trust fund.

41-4924. Qualifications for registration.

41-4925. Application for registration — Fee.

41-4925A. Amendments to plan of operation.

41-4926. Grant or denial of registration.

41-4927. Bylaws of the fund.

41-4928. Records and accounts — Annual statement.

41-4929. Management contract with the administrator — Mandatory provisions.

41-4930. Existing insurance laws to apply to the trust fund with certain exceptions.

41-4931. Taxes.

41-4932. Examination of books, records and accounts.

41-4933. Administrator — Fidelity bonds.

41-4934. Prohibited pecuniary interests in plan management.

41-4935. Political contributions prohibited.

41-4936. Recovery of depleted funds.

41-4937. Impaired trust fund.

41-4938. Liquidation of trust fund.

41-4939. Vouchers for expenditures.

41-4940. Borrowed surplus and subordinated indebtedness.

41-4941. Penalties.

41-4942. Rules — Director — Department of insurance.

41-4943. Application of chapter.

41-4944. Insurance.

41-4945. Personal liability.

41-4946. Actions against the fund, the board, its employees, and administrator subject to the Idaho tort claims act.

41-4948. Legislative review of program. [Repealed.]

Idaho Code § 41-4901

§ 41-4901. Short title. — This chapter shall be known and may be cited as the “Idaho Petroleum Clean Water Trust Fund Act.”

History.

I.C., § 41-4901, as added by 1990, ch. 119, § 1, p. 266.

§ 41-4902. Legislative findings and intent. — (1) The legislature finds that significant quantities of petroleum and petroleum products are being stored in tanks in Idaho to meet the needs of its citizens, foster economic growth and development and the overall quality of life in the state. While most storage tanks are being operated and managed responsibly, there are occasions when releases occur, threatening the public health and safety, and the environment. It is to the benefit of Idaho's citizens to correct any such threats to the public health and safety or environment as quickly and completely as possible. Significant financial resources must be available to investigate and remedy any release. However, reasonably affordable petroleum liability insurance coverage is unavailable to pay for such corrective and cleanup measures. Thus, creation of a fund for corrective actions for petroleum releases would be beneficial to the state and would provide a method for Idaho petroleum storage tank owners or operators to satisfy the financial responsibility requirements imposed on them by the federal environmental protection agency. Such a fund would be created by the imposition of a "transfer fee" of one cent (\$.01) per gallon on the delivery or storage of petroleum products within the state of Idaho. Such a fund would provide moneys for the immediate protection of the public health and safety and the environment, while helping avoid catastrophic losses to the owners and operators which could result in negative impacts on Idaho's economy.

(2) Therefore, it is hereby declared that the intent of the legislature in the passage of this chapter is to create and regulate in the public interest the formation and operation of a liability insurance trust fund that will make contracts of liability insurance available to owners and operators of petroleum storage tanks as defined herein through fair and equitable insurance contracts issued by a state-licensed nonprofit organization meeting reasonable standards as to its administration, reserves, financial soundness and the prompt and fair payment of claims arising out of the legal liability of the public and private entities protected and insured by these contracts, which will also provide for swift corrective action for releases of petroleum or petroleum products from leaking storage tanks. While the release of petroleum from any storage tank in the state may be a

threat to public health and safety and the environment, this fund shall only be available for costs incurred as to those tanks which are covered by a contract of insurance between the owner or operator and the trust fund.

History.

I.C., § 41-4902, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 1, p. 113.

§ 41-4903. Definitions. — For the purposes of this chapter:

(1) “Aboveground storage tank” means any one (1) or a combination of tanks, including pipes connected thereto, that is used to contain an accumulation of petroleum or petroleum products, and the volume of which, including the volume of pipes connected thereto, is less than ten percent (10%) beneath the surface of the ground. This term does not include a heating tank, farm tank or residential tank or any tank with a capacity of one hundred ten (110) gallons or less.

(2) “Accidental release” means any sudden or nonsudden release of petroleum from a storage tank that results in a need for corrective action or compensation for bodily injury or property damage neither expected nor intended by the tank owner or operator.

(3) “Administrator” means the state insurance fund or any person employed by the board of trustees to replace the state insurance fund, employed by the board to administer the Idaho petroleum clean water trust fund.

(4) “Application fee” means the amount paid or payable by an owner or operator applying for a contract of insurance with the trust fund to offset the costs of issuing contracts of insurance and other costs of administering this fund.

(5) “Board” means the board of trustees appointed by the governor.

(6) “Bodily injury” means any bodily injury, sickness, disease or death sustained by any person and caused by an occurrence defined in subsection (19) of this section.

(7) “Contamination” means the presence of petroleum or petroleum products in surface or subsurface soil, surface water, or ground water.

(8) “Commission” means the state tax commission of the state of Idaho.

(9) “Corrective action” means those actions as are reasonably necessary to satisfy applicable federal and state standards in the event of a release into the environment from a petroleum storage tank. Corrective action includes initial corrective action response or actions consistent with a remedial

action to clean up contaminated soil and ground water or address residual effects after initial corrective action is taken, as well as actions necessary to monitor, assess and evaluate a release. Corrective action also includes the cost of removing a tank which is releasing or has been releasing petroleum products and the release cannot be corrected without removing the tank; but corrective action does not include the cost of replacing this tank with another tank.

(10) “Department” means the department of insurance of the state of Idaho.

(11) “Director” means the director of the department of insurance.

(12) “Farm tank” means any tank with a capacity of more than one hundred ten (110) gallons but less than one thousand one hundred (1,100) gallons situated above ground or underground which is used for storing motor fuel for noncommercial purposes and which is located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank must be located on the farm property. “Farm” includes fish hatcheries, rangeland and nurseries with growing operations.

(13) “Free product” means petroleum or petroleum products in the nonaqueous phase, (e.g., liquid not dissolved in water).

(14) “Fund” or “trust fund” means the Idaho petroleum clean water trust fund.

(15) “Heating tank” means any tank with a capacity of more than one hundred ten (110) gallons situated above ground or underground which is used for storing heating oil for consumptive use on the premises where stored.

(16) “Legal defense costs” means any expense that an owner or operator or the trust fund incurs in defending against claims or actions brought by the federal environmental protection agency or a state agency to require corrective action or to recover the costs of corrective action; or by or on behalf of a third party for bodily injury or property damage caused by a release.

(17) “Licensed distributor” means any distributor who has obtained a license under the provisions of [section 63-2427A, Idaho Code](#). If a person

subject to the fee imposed by [section 41-4909\(7\), Idaho Code](#), is not required to obtain a distributor's license under paragraph (a) or (b) of subsection (1) of [section 63-2427A, Idaho Code](#), such person shall apply to the commission for a limited license for the purpose of complying with the requirements of this chapter. Such a limited license shall not be valid for any other purpose. No bond shall be required for a limited license. A holder of a limited license is a "licensed distributor" for the purposes of filing reports, paying fees and other actions necessary to the proper administration and enforcement of this chapter.

(18) "Noncommercial purposes" means not for resale, with respect to motor fuels.

(19) "Occurrence" means an accident, including continuous or repeated exposure to conditions, which resulted in a release into the environment of petroleum products from a petroleum storage tank.

(20) "Operator" means any person in control, or having responsibility for, the daily operations of a petroleum storage tank.

(21) "Owner" means the owner of a petroleum storage tank, except that "owner" does not include any person who, without participation in the management of a petroleum storage tank, holds indicia of ownership primarily to protect the owner's security interest in the tank.

(22) "Person" means any corporation, association, partnership, one (1) or more individuals, or any governmental unit, or agency thereof, other than federal or state agencies.

(23) "Petroleum" and/or "petroleum products" mean crude oil, or any fraction thereof, which is liquid at standard conditions of temperature and pressure (i.e., at sixty (60) degrees fahrenheit and fourteen and seven-tenths (14.7) pounds per square inch absolute). The term includes motor gasoline, gasohol, other alcohol blended fuels, diesel fuel, heating oil and aviation fuel. Biodiesel and biodiesel blends, as those terms are defined in [section 63-2401, Idaho Code](#), ethanol, and natural gasoline are also petroleum or petroleum products.

(24) "Property damage" means injury or destruction to tangible property caused by an occurrence.

(25) “Release” means any spilling, leaking, emitting, discharging, escaping, leaching, or disposing from a petroleum storage tank into ground water, surface water, or surface or subsurface soils.

(26) “Residential tank” means any tank with a capacity of more than one hundred ten (110) gallons but less than one thousand one hundred (1,100) gallons situated above ground or underground which is used for storing motor fuel for noncommercial purposes and which is located on property used primarily for dwelling purposes.

(27) “Site” means a single parcel of property where petroleum or petroleum products are stored in a petroleum storage tank and includes all contiguous land, structures, other appurtenances, surface water, ground water, surface and subsurface soil, and subsurface strata within and beneath the property boundary.

(28) “State” means the state of Idaho or any office, department, agency, authority, commission, board, institution, hospital, college, university or other instrumentality thereof.

(29) “Tank” means a stationary device designed to contain an accumulation of petroleum or petroleum products and constructed of nonearthen materials (e.g., concrete, steel, plastic) that provide structural support.

(30) “Trustees” means the trustees of the Idaho petroleum clean water trust fund, who are appointed by the governor pursuant to this chapter.

(31) “Underground storage tank” means any one (1) or combination of tanks, including underground pipes connected thereto, that is used to contain an accumulation of petroleum or petroleum products, and the volume of which, including the volume of underground pipes connected thereto, is ten percent (10%) or more beneath the surface of the ground. This term does not include any:

- (a) Farm or residential tank of one thousand one hundred (1,100) gallons or less capacity used for storing motor fuel for noncommercial purposes;
- (b) Tank used solely for storing heating oil for consumptive use on the premises where stored;
- (c) Septic tank;

- (d) Pipeline facility including gathering lines regulated under:
 - (i) The natural gas pipeline safety act of 1968 (49 U.S.C. app. 1671, et seq.); or
 - (ii) The hazardous liquid pipeline safety act of 1979 (49 U.S.C. app. 2001, et seq.); or
 - (iii) State laws comparable to the provisions of the law referred to in paragraph (d)(i) or (d)(ii) of this subsection as an intrastate pipeline facility;
- (e) Surface impoundment, pit, pond or lagoon;
- (f) Storm water or wastewater collection system;
- (g) Flow-through process tank;
- (h) Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations;
- (i) Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor;
- (j) Tanks with a capacity of one hundred ten (110) gallons or less.

The term “underground storage tank” does not include any pipes connected to any tank which is described in paragraphs (a) through (i) of this definition.

(32) “Underground storage tank regulations” means regulations for petroleum storage tanks promulgated by the United States environmental protection agency (EPA) pursuant to subtitle I of the solid waste disposal act, as amended by the resource conservation and recovery act, regulations promulgated by the state of Idaho as part of a state program for underground storage tank regulation under subtitle I, or other regulations affecting underground storage tank operations and management, including the international fire code adopted by the state of Idaho.

History.

I.C., § 41-4903, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 2, p. 113; am. 1995, ch. 132, § 12, p. 565; am. 1998, ch. 428, § 6, p. 1346;

am. 2002, ch. 86, § 9, p. 195; am. 2003, ch. 96, § 2, p. 281; am. 2007, ch. 37, § 3, p. 88; am. 2009, ch. 21, § 1, p. 48; am. 2011, ch. 6, § 1, p. 14.

STATUTORY NOTES

Cross References.

State insurance fund, § 72-901 et seq.

State tax commission, § 63-101 et seq.

Amendments.

The 2007 amendment, by ch. 37, added the last sentence in subsection (23).

The 2009 amendment, by ch. 21, substituted “under paragraph (a) or (b) of subsection (1) of [section 63-2427A, Idaho Code](#)” for “under the provisions of chapter 24, title 63, Idaho Code” in subsection (17).

The 2011 amendment, by ch. 6, inserted “ethanol, and natural gasoline” near the end of subsection (23).

Federal References.

The natural gas pipeline safety act of 1968, referred to in paragraph (31)(d)(i), has been repealed. See now [49 USCS § 60101 et seq.](#)

The hazardous liquid pipeline safety act of 1979, referred to in paragraph (31)(d)(ii), has been repealed. See [49 USCS § 60101 et seq.](#)

For subtitle I of the solid waste disposal act, referred to in subsection (32), see [42 USCS § 6991 et seq.](#)

The resource conservation and recovery act, referred to in subsection (32), is codified as [42 USCS § 6901 et seq.](#)

Compiler’s Notes.

The words in parentheses so appeared in the law as enacted.

Effective Dates.

Section 11 of S.L. 1998, ch. 428 declared an emergency and provided this act shall be in full force and effect on and after its passage and approval. Approved April 3, 1998.

§ 41-4904. Board of trustees of the fund. — (1) The governor shall appoint seven (7) persons to be the board of trustees of the Idaho petroleum clean water trust fund. One (1) member shall be a member of the state senate, one (1) member shall be a member of the state house of representatives, one (1) member shall be a representative of the financial community with expertise in the area of insurance, accounting or finance, one (1) member shall be an engineer, geologist or similarly trained scientist with experience in environmental remediation and three (3) members shall be wholesale distributors of petroleum products. The governor shall appoint a chairman from the seven (7) members. The members shall be appointed for terms of four (4) years, except that all vacancies shall be filled for the unexpired term, provided that the first two (2) appointments the governor makes after the effective date of this act shall serve a term of two (2) years and the other five (5) members shall serve a term of four (4) years. Thereafter, a member shall serve a term of four (4) years. A certificate of appointment shall be filed in the office of the secretary of state. A majority of the members shall constitute a quorum for the transaction of all business or the exercise of any power or function of the Idaho petroleum clean water trust fund. Members of the board of trustees shall receive a compensation for service as prescribed in [section 59-509\(n\), Idaho Code](#).

(2) The administrator of the fund shall be the state insurance fund unless replaced by the board of trustees with another person. The administrator shall serve at the pleasure of the board of trustees. The board of trustees may appoint and employ such other persons as may be required by the board and shall prescribe the duties and compensation of each such person.

(3) It shall be the duty of the board of trustees to direct the policies and operation of the fund to assure that it is run as an efficient insurance company, remains actuarially sound and maintains the public purposes for which the Idaho petroleum clean water trust fund was created.

History.

[I.C., § 41-4904](#), as added by 2003, ch. 96, § 4, p. 281; am. 2004, ch. 175, § 1, p. 552; am. 2006, ch. 140, § 2, p. 402; am. 2018, ch. 21, § 1, p. 33.

STATUTORY NOTES

Cross References.

State insurance fund, § 72-901.

Amendments.

The 2006 amendment, by ch. 140, substituted “59-509(n)” for “59-509(h)” near the end of subsection (1).

The 2018 amendment, by ch. 21, rewrote the second sentence in subsection (1), which formerly read: “One (1) member shall be a member of the state senate, one (1) member shall be a member of the state house of representatives, one (1) member shall be a representative of the financial community with expertise in the area of insurance, accounting or finance, one (1) member shall be an engineer, geologist or similarly trained scientist with experience in environmental remediation, one (1) member shall be a wholesale distributor of petroleum products who participates in the trust fund and has less than five million (5,000,000) gallons in annual sales, one (1) member shall be a wholesale distributor of petroleum products who participates in the trust fund and has from five million (5,000,000) to ten million (10,000,000) gallons in annual sales, and one (1) member shall be a retailer of petroleum products who participates in the trust fund and has more than ten million (10,000,000) gallons in annual sales.”

Legislative Intent.

Section 1 of S.L. 2006, ch. 140 provided: “Legislative Intent. In 2003, the Legislature enacted legislation which amended the Idaho Petroleum Clean Water Trust Fund Act and created a seven person board of trustees. This is a part-time board whose members receive a minimum compensation for services. It was not the intent of the Legislature for this compensation to interfere with or disqualify Individual Retirement Accounts (IRAs) of the individual board members under federal tax laws. This act is intended to reflect that the income received is an honorarium provided in [Section 59-509\(n\), Idaho Code](#). The Controller’s Office of the State of Idaho is to correct and refile all necessary tax forms with the Internal Revenue Service to reflect this change in law. Any contributions paid to the Public Employee Retirement system shall be refunded and no service shall be credited for any period since January 1, 2003.”

Compiler's Notes.

Former § 41-4904 was amended and redesignated as § 41-4905.

The phrase “the effective date of this act” near the middle of subsection (1) refers to the effective date of S.L. 2003, Chapter 96, which was effective July 1, 2003.

Effective Dates.

Section 3 of S.L. 2006, ch. 140 declared an emergency retroactively to January 1, 2003 and approved March 22, 2006.

§ 41-4905. Creation, authorization and management of the Idaho petroleum clean water trust fund. — (1) The Idaho petroleum clean water trust fund is hereby created, subject to the direction and supervision of the board, and the administrator is hereby authorized to utilize this trust fund for the purpose of insuring governmental and private entities who are owners and operators of petroleum storage tanks against the costs of corrective action and compensating third parties that are legally entitled to receive compensation for bodily injury and property damage arising out of accidental releases of petroleum from petroleum storage tanks covered by a contract of insurance between the owner or operator and the trust fund.

(2) Nothing in this chapter shall enlarge or otherwise adversely affect the legal liability of any legal entity insured by the trust fund, and any immunity or other bar to a civil lawsuit under Idaho or federal law shall remain in effect. The fact that the trust fund insures the legal liability of any legal entity and thus may relieve the entity or an employee of the entity from the payment of any judgment arising from a civil lawsuit, shall not be communicated to the trier of fact in such a lawsuit.

(3) The trust fund shall consist of all application fees and all transfer fees collected pursuant to [section 41-4909, Idaho Code](#), all other moneys received and paid into the trust fund, property and securities acquired by or through the use of money belonging to the trust fund, money loaned to the trust fund under the terms and agreements of a subordinated note of indebtedness or borrowed surplus as hereinafter defined and authorized, and of interest earned on money and securities owned or in the possession of the trust fund under an agreement that such investment earnings can accrue to the benefit of the trust fund.

(4) The trust fund shall have the powers and privileges of a nonprofit corporate entity and in its name may sue and be sued in any court of competent jurisdiction, and may lease and maintain offices and space for its departmental and operational facilities, subject to the provisions of chapters 6 and 7, title 41, Idaho Code.

(5) The administrator shall enter into a management and administrative contract with the trust fund to provide the following services:

(a) Administrative functions including the hiring of qualified personnel and the payment of salaries and wages earned, plus recordkeeping for the personnel hired to provide services for the trust fund.

(b) Accounting and recordkeeping of all receipts and disbursements of the trust fund.

(c) Underwriting functions of the trust fund to issue contracts of liability insurance and charge appropriate application fees under [section 41-4909, Idaho Code](#), for such contracts and keep accurate statistical records.

(d) Claims handling functions of the trust fund to process and pay appropriate claims in a prompt, fair and reasonable manner.

(e) Auditing functions of the trust fund to maintain accurate records of receipts and disbursements by the trust fund and accurate reporting of statistics by owners or operators of storage tanks covered by a contract of insurance issued by the trust fund.

(f) Actuarial functions of the trust fund to maintain credible and viable statistics, sufficient operating fund balances, and appropriate loss reserves.

(g) Computer and data processing functions to assist the trust fund in maintaining complete and accurate records in a timely manner and issue loss payments and other disbursements, as well as provide individual statistics and records of storage tanks covered by a contract of insurance issued by the trust fund.

(h) Computer programming functions to maintain a proficient and current data processing system for the trust fund.

(i) Legal services for the trust fund.

(j) Any and all other functions the administrator deems prudent and reasonable to assure the successful operation of the trust fund.

(6) The Idaho petroleum clean water trust fund shall be administered without liability on the part of the state insurance fund or the state of Idaho beyond the amount of said trust fund.

(7) The administrator shall have the power to receive and account for all moneys paid into the trust fund, accept and evaluate applications for

insurance coverage and issue the contracts of insurance and evaluate, investigate and adjust claims made against the trust fund and make agreements for corrective actions or compensation to third parties for bodily injury or property damage those parties may be legally entitled to receive from the trust fund in accordance with the provisions of this chapter.

(8) The administrator shall establish underwriting procedures to issue contracts of insurance and claim procedures. The administrator shall be given notice of all applications, hearings and proceedings involving the rights of the trust fund and shall represent the trust fund in all proceedings. The administrator's decisions shall be written, and shall include all reasons for his decisions and shall be subject to judicial review in the district court of Ada county; provided, however, that the administrator and the trust fund shall not be liable for alleged bad faith or other legal theories based on any method or timing of the claims processed on his decision.

(9) The administrator may employ legal counsel or obtain legal counsel through the attorney general concerning all legal matters arising out of the existence and operation of the trust fund, including claims made against the contracts of insurance issued by the administrator of the trust fund.

(10) The administrator may also employ such employees or contract for such services as are necessary to assist in the administration of the trust fund, and all such administrative expenses incurred by the state insurance fund for the benefit of the trust fund shall be reimbursed by the trust fund.

History.

I.C., § 41-4904, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 3, p. 113; am. 1998, ch. 428, § 7, p. 1346; am. and redesign. 2003, ch. 96, § 3, p. 281.

STATUTORY NOTES

Cross References.

State insurance fund, § 72-901.

Compiler's Notes.

This section was formerly compiled as § 41-4904.

Former § 41-4905 was amended and redesignated as § 41-4906.

Effective Dates.

Section 11 of S.L. 1998, ch. 428 declared an emergency and provided this act shall be in full force and effect on and after its passage and approval. Approved April 3, 1998.

§ 41-4906. Limits of liability for contracts of insurance issued by the administrator. — (1) Contracts of insurance issued by the administrator shall contain the following per occurrence and annual aggregate limits of liability for paying the costs of corrective action and compensating third parties who are legally entitled to receive compensation for bodily injury and property damage arising out of accidental releases from covered petroleum storage tanks:

(a) For owners or operators of heating tanks, farm tanks or residential tanks, no more than one hundred thousand dollars (\$100,000) per occurrence and no more than one hundred thousand dollars (\$100,000) annual aggregate;

(b) For nonmarketers of petroleum products who are owners or operators of above ground and underground storage tanks and who consume ten thousand (10,000) gallons or less of petroleum products each month, no more than five hundred thousand dollars (\$500,000) per occurrence and no more than one million dollars (\$1,000,000) annual aggregate;

(c) For owners or operators of one (1) to one hundred (100) covered underground petroleum storage tanks, no more than one million dollars (\$1,000,000) per occurrence and no more than one million dollars (\$1,000,000) annual aggregate;

(d) For owners or operators of one hundred and one (101) or more covered underground petroleum storage tanks, no more than one million dollars (\$1,000,000) per occurrence and no more than two million dollars (\$2,000,000) annual aggregate; and

(e) For owners or operators of covered above ground petroleum storage tanks, no more than one million dollars (\$1,000,000) per occurrence and no more than one million dollars (\$1,000,000) annual aggregate.

(2) Legal defense costs shall be disregarded for purposes of determining whether the limits specified in subsection (1) of this section have been reached.

(3) Benefits provided by the trust fund shall be primary and shall not be construed to be excess over and above any other valid and collectible

insurance.

(4) If an owner or operator owns or operates more than one (1) of the types of petroleum storage tanks listed in subsection (1) of this section, then the limit of liability applicable to the type of petroleum storage tank from which the accidental release occurred shall apply. In no event shall any of the limits of liability in subsection (1) of this section be combined to exceed the highest per occurrence and annual aggregate limits of liability for any single category in subsections (1)(a) through (1)(e) of this section applicable to an insured owner or operator.

History.

I.C., § 41-4905, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 4, p. 113; am. and redesign. 2003, ch. 96, § 5, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4905.

Former § 41-4906 was amended and redesignated as § 41-4907.

§ 41-4907. Owner or operator financial responsibility. — (1) The owner or operator shall reimburse the trust fund for all dollars expended, excluding legal defense costs, up to but not exceeding the following amounts:

(a) With respect to a heating tank — one hundred dollars (\$100) per annum; (b) With respect to a farm tank or residential tank — two thousand dollars (\$2,000) per annum; (c) With respect to an above ground storage tank or underground storage tank, as defined in [section 41-4903, Idaho Code](#) — ten thousand dollars (\$10,000) per annum.

(2) Payments by the trust fund shall not be made contingent on prior payment of the reimbursement herein required.

History.

[I.C., § 41-4906](#), as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 6, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4906.

Former § 41-4907 was amended and redesignated as § 41-4908.

§ 41-4908. Exclusiveness of remedy. — If compensation is made from the trust fund to a third party for property damage or personal injury, then that third party shall not recover again for the damage actually compensated by the trust fund pursuant to the collateral source doctrine or any other rule of law permitting duplicate recovery.

History.

I.C., § 41-4907, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 7, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4907.

Former § 41-4908 was amended and redesignated as § 41-4909.

CASE NOTES

Cited Baird Oil Co., Inc. v. Idaho State Tax Comm'n, 144 Idaho 229, 159 P.3d 866 (2007).

§ 41-4909. Source of trust fund — Application fees — Application for enrollment — Transfer fees. — (1) Every owner or operator of an underground storage tank may, if he desires to apply to the trust fund to insure the underground tank, make application for and pay into the trust fund an initial application fee set by the administrator, but not to exceed twenty-five dollars (\$25.00) for each tank for which application for coverage is made.

(2) Every owner or operator of an aboveground storage tank may, if he desires to apply to the trust fund to insure the aboveground tank, make application for and pay into the trust fund an initial application fee set by the administrator, but not to exceed twenty-five dollars (\$25.00) for each tank for which application for coverage is made.

(3) Every owner or operator of a farm tank or residential tank may, if he desires to apply to the trust fund to insure the tank, make application for and pay into the trust fund an initial application fee set by the administrator, but not to exceed twenty-five dollars (\$25.00) for each tank for which application for coverage is made.

(4) Every owner or operator of a heating tank may, if he desires to apply to the trust fund to insure the tank, make application for and pay into the trust fund an initial application fee set by the administrator, but not to exceed five dollars (\$5.00) for each tank for which application for coverage is made.

(5) The application for insurance shall be made to the administrator on forms furnished and prescribed by the administrator for the purpose of eliciting reasonably available information as to the type and use of the storage tank, the type of business enterprise of the tank owner or operator, the age of the storage tank, the materials used in the construction of the tank and the inside and outside protective coatings and other corrosion protective measures, leak detection methods, spill and overfill prevention methods of the tank, the location of the tank and its proximity to roads and buildings, the foundation and type of material used as a bedding and fill for the tank, any available inspection records of the tank including the gallons of petroleum products entered into the tank and the gallon dispersements from

the tank, and other information that is reasonably prudent in order to obtain a sufficient body of statistical data to determine the relative hazards of various categories of tanks, the potential that future leaks or discharges may occur, and the conditions under which cleanup costs and personal injury and property damage costs may occur and vary in the severity of the release and the resultant costs to the trust fund.

(6) The administrator shall act upon the application for insurance with all reasonable promptness, and the administrator shall make such investigations of the applicant as the administrator deems advisable to determine if the information contained in the application for insurance is accurate and complete. The administrator shall determine if the applicant's storage tanks meet all the eligibility requirements and promptly notify the applicant of the acceptance or nonacceptance of the application for insurance. The absence of unknown data requested on the application shall not preclude an applicant's acceptance for coverage by the trust fund, if the applicant is otherwise eligible for insurance under this chapter.

(7) In addition to the application fees received by the trust fund pursuant to this section, the trust fund shall receive the revenue produced by the imposition of a "transfer fee" of one cent (1¢) per gallon on the delivery or storage of all petroleum products as defined in subsection (23) of [section 41-4903, Idaho Code](#), delivered or stored within the state of Idaho. This transfer fee is hereby imposed upon the first licensed distributor who receives, as receipt is determined in [section 63-2403, Idaho Code](#), a petroleum product within this state for the privilege of engaging in the delivery or storage of petroleum products whose delivery or storage may present the danger of a discharge into the environment and thus create the liability to be funded. The fee imposed by this subsection shall not apply to: (a) petroleum or petroleum products which are first delivered or stored in this state in a container of fifty-five (55) gallons or less if such container is intended to be transferred to the ultimate consumer of the petroleum or petroleum products; or (b) petroleum or petroleum products delivered or stored in this state for the purpose of packaging or repackaging into containers of fifty-five (55) gallons or less if such container is intended to be transferred to the ultimate consumer of the petroleum or petroleum products.

(8) The transfer fee shall be collected by the commission on all petroleum products delivered or stored within this state after April 1, 1990. This transfer fee shall be in addition to any excise tax imposed on motor fuel or other petroleum products and shall be remitted to the commission with the distributor's monthly report as required in [section 63-2406, Idaho Code](#). The distributor may deduct from his monthly report those gallons of petroleum products returned to a licensed distributor's refinery or pipeline terminal storage or exported from the state when supported by proper documents approved by the commission. For the purpose of carrying out its duties under the provisions of this chapter, the commission shall have the powers and duties provided in sections 63-3038, 63-3039, 63-3042 through 63-3066, 63-3068, 63-3071, and 63-3074 through 63-3078, Idaho Code, which sections are incorporated by reference herein as though set out verbatim.

(9) No person shall be excused from liability for any duty or fee imposed in this chapter for failure to obtain a distributor's license.

(10) The director shall certify to the commission when the unencumbered balance in the trust fund equals thirty-five million dollars (\$35,000,000). Effective the first day of the second month following the date of such certification, the imposition of the transfer fee shall be suspended. Thereafter, the director shall certify to the commission when the unencumbered balance in the trust fund equals twenty-five million dollars (\$25,000,000). Effective the first day of the second month following the date of such certification, the imposition of the transfer fee shall be reinitiated.

History.

[I.C., § 41-4908](#), as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 5, p. 113; am. 1998, ch. 103, § 1, p. 353; am. 1998, ch. 428, § 8, p. 1346; am. 2000, ch. 419, § 1, p. 1363; am. and redesign. 2003, ch. 96, § 8, p. 281; am. 2007, ch. 194, § 1, p. 570.

STATUTORY NOTES

Amendments.

This section was amended by two 1998 acts which appear to be compatible and have been compiled together.

The 1998 amendment, by ch. 103, § 1, in the second sentence of subsection (7), substituted “licensed distributor who receives, as receipt is determined in [section 63-2403, Idaho Code](#), a petroleum product” for “licensed distributor who transfers title to a petroleum product”, and in the second sentence of subsection (8), substituted “excise tax imposed on motor fuel” for “excise tax imposed on gasoline and/or aircraft engine fuel.”

The 1998 amendment, by ch. 428, § 8, in subsection (7), substituted “subsection (24) of [section 41-4903, Idaho Code](#)” for “subsection (23) of [section 41-4903, Idaho Code](#).”

The 2007 amendment, by ch. 194, in subsection (7), substituted “subsection (23)” for “subsection (24)”; and in subsection (10), in the first sentence, substituted “thirty-five million dollars” for “twenty-five million dollars,” and in the third sentence, substituted “twenty-five million dollars” for “fifteen million dollars.”

Compiler’s Notes.

This section was formerly compiled as § 41-4908.

Former § 41-4609 was amended and redesignated as § 41-4910.

Effective Dates.

Section 11 of S.L. 1998, ch. 428 declared an emergency and provided this act shall be in full force and effect on and after its passage and approval. Approved April 3, 1998.

CASE NOTES

[Application.](#)

[Appropriation unconstitutional.](#)

[Constitutionality.](#)

[Implied repeal of § 63-2431.](#)

[Application.](#)

Court's decision that appropriation of the proceeds from the per-gallon transfer fee assessed for engaging in the privilege of delivering petroleum products in state could not be constitutionally applied to fund the Idaho petroleum clean water trust fund was to be applied in a modified, prospective fashion: decision was to be applied to all pending actions at the date of court's decision and to actions arising in future but was not to be applied retroactively. *V-1 Oil Co. v. Idaho Petro. Clean Water Trust Fund*, 128 Idaho 890, 920 P.2d 909, cert. denied, 519 U.S. 1009, 117 S. Ct. 514, 136 L. Ed. 2d 403 (1996).

Appropriation Unconstitutional.

The per-gallon transfer fee assessed for engaging in the privilege of delivering petroleum products in state was not reasonably related to the benefits provided by the Idaho petroleum clean water trust fund Act's (trust fund) insurance program and, therefore, was a tax; as such, the appropriation of the revenue raised from the transfer fee to the trust fund was unconstitutional since Idaho *Const., Art. VII, § 17* mandates that all revenue raised from any tax on gasoline, such as the transfer fee at issue, must go toward construction, repair, maintenance and traffic supervision of the public highways. *V-1 Oil Co. v. Idaho Petro. Clean Water Trust Fund*, 128 Idaho 890, 920 P.2d 909, cert. denied, 519 U.S. 1009, 117 S. Ct. 514, 136 L. Ed. 2d 403 (1996).

Constitutionality.

The creation and collection of per-gallon transfer fee assessed for engaging in the privilege of delivering petroleum products in state was not unconstitutional, although revenue raised from the imposition of the transfer fee must be appropriated by the Idaho Legislature for uses consistent with *Art. VII, § 17 of the Idaho Constitution*; as such, petroleum distributor was not entitled to refund of the transfer fees it paid. *V-1 Oil Co. v. Idaho Petro. Clean Water Trust Fund*, 128 Idaho 890, 920 P.2d 909, cert. denied, 519 U.S. 1009, 117 S. Ct. 514, 136 L. Ed. 2d 403 (1996).

Implied Repeal of § 63-2431.

Because this section is an inconsistent later statute which has the same subject and purpose as § 63-2431, and there is no reasonable alternative to a holding that the later statute impliedly repealed the earlier statute, to the

extent the two statutes are inconsistent, this section impliedly repeals § 63-2431. *V-1 Oil Co. v. Idaho State Tax Comm’n*, 134 Idaho 716, 9 P.3d 519 (2000).

OPINIONS OF ATTORNEY GENERAL

Constitutionality.

Subsection (7) of this section, which imposes a transfer fee of one cent per gallon on the delivery or storage of all petroleum products within the state, does not violate Idaho *Const., Art. VII, § 17*, which requires that the proceeds of any tax on gasoline and like motor vehicle fuels sold or used to propel motor vehicles upon the highways of this state be used for highway purposes; the “transfer fee” established in subsection (7) of this section is not a “tax on gasoline and like motor vehicle fuels sold or used to propel motor vehicles upon the highways of this state.” OAG 90-2.

Transfer Fee.

The transfer fee established in subdivision (8) of this section is reasonably related to the services provided and is not primarily designed to raise revenue for the state. OAG 90-2.

Even if the transfer fee provided for in this section were to be construed as a tax, the tax probably would not be construed as a tax on “gasoline and like motor vehicle fuels sold or used to propel motor vehicles upon the highways of this state” within the meaning of Idaho *Const., Art. VII, § 17*; if the transfer fee were a tax, the tax would be on the acts of delivery and storage of all petroleum products rather than on motor vehicle fuels used to propel motor vehicles on the highway. Thus, even if the transfer fee were construed to be a tax, the tax would not violate Idaho *Const., Art. VII, § 17*. OAG 90-2.

§ 41-4910. Distribution of application fees and transfer fees. — (1) The application fees and the transfer fees collected as provided in this chapter shall be promptly remitted to the state treasurer for deposit in the Idaho petroleum clean water trust fund. The transfer fees and accumulated interest which accrued to the fund prior to August 3, 1995, shall remain in the fund. The transfer fees and accumulated interest, which have been held in a separate suspense account since August 3, 1995, shall be distributed as provided in subsection (4) of this section. The transfer fees and accumulated interest which accrue to the Idaho petroleum clean water trust fund subsequent to April 1, 1997, shall be distributed monthly thereafter as provided in subsection (5) of this section.

(2) An amount of money equal to the actual cost of collecting, administering and enforcing the transfer fee by the commission, as determined by it, shall be retained by the commission. The amount retained by the commission shall not exceed the amount authorized to be expended by appropriation by the legislature. Any unencumbered balance in excess of the actual cost of collection, administering and enforcing the transfer fee requirements by the commission at the end of each fiscal year shall be remitted to the state treasurer for deposit into the Idaho petroleum clean water trust fund.

(3) From the receipts of the transfer fee, an amount of money shall be distributed to the state refund account established under [section 63-3067, Idaho Code](#), sufficient to reimburse that account for all current refund claims under this chapter paid from that account. Any refunds due and owing from the commission under this chapter shall be paid from the state refund account and those moneys are hereby continuously appropriated for that purpose.

(4) For the distribution on April 1, 1997, the balance of the transfer fees and accumulated interest accruing to the separate suspense account established for such fees on August 3, 1995, which remain after distributing the amounts specified in subsections (2) and (3) of this section, shall be distributed as follows: (a) Twenty percent (20%) to the Idaho petroleum clean water trust fund established in [section 41-4905, Idaho Code](#); (b) Three

percent (3%) to the Idaho department of parks and recreation in accordance with subparagraphs 1., 2., and 3. of paragraph (f), subsection (1) of [section 63-2412, Idaho Code](#); and (c) The remainder shall be distributed:

(i) Six million dollars (\$6,000,000) to the state highway account for administration by the Idaho transportation department as provided in [section 41-4910A, Idaho Code](#); and (ii) The balance remaining to the highway distribution account established in [section 40-701, Idaho Code](#).

(5) For the distribution at the end of fiscal year 1997 and monthly thereafter, the balance of the transfer fees and accumulated interest accruing to the Idaho petroleum clean water trust fund which remain after distributing the amounts specified in subsections (2) and (3) of this section, shall be distributed as follows: (a) Seventy-seven percent (77%) to the highway distribution account established in [section 40-701, Idaho Code](#); and (b) Three percent (3%) to the Idaho department of parks and recreation in accordance with subparagraphs 1., 2., and 3. of paragraph (f), subsection (1) of [section 63-2412, Idaho Code](#).

History.

[I.C., § 41-4909](#), as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 6, p. 113; am. 1997, ch. 398, § 1, p. 1260; am. 1999, ch. 320, § 2, p. 815; am. and redesisg. 2003, ch. 96, § 9, p. 281; am. 2009, ch. 332, § 5, p. 962.

STATUTORY NOTES

Cross References.

State highway account, § 40-702.

Amendments.

The 2009 amendment, by ch. 332, updated the paragraph reference in subsections (4)(b) and (5)(b) to reflect the 2009 amendment of § 63-2412.

Legislative Intent.

Section 6 of S.L. 2009, ch. 332 provided: “It is legislative intent, in light of changing consumption patterns relating to motor vehicle fuels, including gasohol, biodiesel and biodiesel blends, to review on an annual basis the

distributions to the State Highway Account provided for in Sections 63-2412(1)(e) and 63-2418(3), Idaho Code.”

Compiler’s Notes.

This section was formerly compiled as § 41-4909.

Former § 41-4910 was amended and redesignated as § 41-4910A.

This section was amended by S.L. 2009, ch. 333, § 3, effective July 1, 2010. The effective date of that amendment was changed by S.L. 2010, ch. 129, § 1 to July 1, 2011. However, S.L. 2011, ch. 68, § 2 repealed S.L. 2009, ch. 333, § 3, leaving the section as last amended by S.L. 2009, ch. 332, § 5.

Effective Dates.

Section 3 of S.L. 1997, ch. 398 declared an emergency. Approved March 24, 1997.

Section 7 of S.L. 2009, ch. 332 provided the act should take effect on and after July 1, 2009.

CASE NOTES

[Appropriation unconstitutional.](#)

[Constitutionality.](#)

[Appropriation Unconstitutional.](#)

The per-gallon transfer fee assessed for engaging in the privilege of delivering petroleum products in state was not reasonably related to the benefits provided by the Idaho petroleum clean water trust fund act’s (trust fund) insurance program and, therefore, was a tax, as such, the appropriation of the revenue raised from the transfer fee to the Trust Fund was unconstitutional since Idaho [Const., Art. VII, § 17](#), mandates that all revenue raised from any tax on gasoline, such as the transfer fee at issue, must go toward construction, repair, maintenance and traffic supervision of the public highways. [V-1 Oil Co. v. Idaho Petro. Clean Water Trust Fund](#), 128 Idaho 890, 920 P.2d 909, cert. denied, 519 U.S. 1009, 117 S. Ct. 514, 136 L. Ed. 2d 403 (1996).

[Constitutionality.](#)

The 1997 amendment to this section that allocates 20% of the proceeds from the tax to the Idaho petroleum clean water trust fund conforms to the requirements of Idaho [Const., Art. VII, § 17](#). [V-1 Oil Co. v. Idaho State Tax Comm'n](#), 134 Idaho 716, 9 P.3d 519 (2000).

OPINIONS OF ATTORNEY GENERAL

Constitutionality.

Section 41-4908(7) [now 41-4909(7)], which imposes a transfer fee of one cent per gallon on the delivery or storage of all petroleum products within the state, does not violate Idaho [Const., Art. 7, § 17](#), which requires that the proceeds of any tax on gasoline and like motor vehicle fuels sold or used to propel motor vehicles upon the highways of this state be used for highway purposes; the “transfer fee” is not a “tax on gasoline and like motor vehicle fuels sold or used to propel motor vehicles upon the highways of this state.” OAG 90-2.

§ 41-4910A. Apportionment of moneys transferred to the state highway account from the Idaho petroleum clean water trust fund suspense account on April 1, 1997. — Of the moneys transferred to the state highway account pursuant to the distribution in [section 41-4910\(4\)\(c\)\(i\), Idaho Code](#), an amount not to exceed six million dollars (\$6,000,000) shall be administered by the Idaho transportation department for use as the state and local match for federal highway administration (FHWA) and federal emergency management agency (FEMA) road and bridge projects. Such moneys shall be used exclusively for repair and restoration of local and state roads and bridges damaged by the 1996, 1997 and 1998 natural disasters in the counties of Adams, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Butte, Clearwater, Custer, Elmore, Fremont, Gem, Idaho, Jefferson, Kootenai, Latah, Lemhi, Lewis, Madison, Nez Perce, Owyhee, Payette, Shoshone, Valley and Washington. When apportionment of moneys under this section is sufficient to meet the purposes for which the moneys are designated, but not to exceed six million dollars (\$6,000,000), any remaining amounts shall be returned to the highway distribution account established in [section 40-701, Idaho Code](#).

History.

[I.C., § 41-4909A](#), as added by 1997, ch. 398, § 2, p. 1260; am. 1998, ch. 181, § 2, p. 667; am. 1999, ch. 194, § 2, p. 504; am. 1999, ch. 320, § 3, p. 815; am. and redesisg. 2003, ch. 96, § 10, p. 281.

STATUTORY NOTES

Amendments.

This section was amended by two 1999 acts which appear to be compatible and have been compiled together.

The 1999 amendment, by ch. 194, in the second sentence, substituted “1996, 1997 and 1998” for “1997,” and inserted “Lemhi, Lewis” preceding “Madison.”

The 1999 amendment, by ch. 320, in the last sentence, substituted “highway distribution account” for “restricted highway fund”, and

substituted “40-701” for “40-701A.”

Compiler’s Notes.

This section was formerly compiled as § 41-4909A.

Former § 41-4910A was amended and redesignated as § 41-4911A.

Effective Dates.

Section 3 of S.L. 1997, ch. 398 declared an emergency. Approved March 24, 1997.

Section 3 of S.L. 1998, ch. 181 declared an emergency and provided this act shall be in full force and effect on and after its passage and approval, and retroactively to December 31, 1997. Approved March 20, 1998.

§ 41-4911. Issuance of contracts of insurance by the administrator of the Idaho petroleum clean water trust fund — Deferral. — (1) The administrator may issue a contract of insurance to an owner or operator of a petroleum storage tank that, based upon a consideration of the owner or operator's application for insurance and appropriate investigation by the administrator, meets the eligibility provisions of this chapter and the underwriting requirements established by the administrator.

(2) The administrator may defer issuing contracts of insurance to certain categories of petroleum storage tank owners or operators if necessary for the sound operation of the trust fund.

(3) The administrator shall consider the following factors in determining whether to defer the issuance of contracts of insurance to any category of petroleum storage tank owners or operators:

- (a) The underwriting capacity of the trust fund;
- (b) Any requirement of federal or state law or regulation imposed on any category of petroleum storage tank owners or operators to demonstrate financial responsibility for corrective action and compensation to third parties for bodily injury and property damage arising from accidental releases from petroleum storage tanks;
- (c) The ability of the administrator to process insurance applications from different categories of petroleum storage tank owners or operators.

(4) Any decision by the administrator to defer issuing contracts of insurance to any category of petroleum storage tank owners or operators shall be documented in the plan of operation, or an amendment thereto, submitted to the director of the department of insurance pursuant to sections 41-4925 or 41-4925A, Idaho Code, and subject to the director's approval.

(5) The administrator may issue contracts of insurance to deferred categories of petroleum storage tank owners or operators when the need for deferral documented in subsection (4) of this section no longer exists, as demonstrated by an amendment to the plan of operation submitted to and approved by the director of the department of insurance pursuant to [section 41-4925A, Idaho Code](#).

History.

I.C., § 41-4910, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 7, p. 113; am. and redesign. 2003, ch. 96, § 11, p. 281.

STATUTORY NOTES**Compiler's Notes.**

This section was formerly compiled as § 41-4910.

Former § 41-4911 was amended and redesignated as § 41-4912.

§ 41-4911A. Provisions of contracts of insurance — Renewal. — (1)

The contracts of insurance issued by the administrator shall meet the requirements of this chapter. To the extent consistent with this chapter, the contracts of insurance shall also satisfy the provisions of any requirement imposed by federal or state law or regulation on any category of petroleum storage tank owners or operators to demonstrate financial responsibility for corrective action and compensation to third parties for bodily injury and property damage arising from accidental releases from petroleum storage tanks.

(2) Upon receipt of an annual application fee not exceeding twenty-five dollars (\$25.00) for each aboveground tank, underground tank, farm tank or residential tank, or not to exceed five dollars (\$5.00) for each heating tank covered by a contract of insurance, and upon receipt of evidence that the petroleum storage tanks continue to meet the eligibility provisions of this chapter and the underwriting requirements established by the administrator, the administrator shall issue an annual renewal of the contract of insurance to the owner or operator of said petroleum storage tanks.

History.

I.C., § 41-4910A, as added by 1991, ch. 59, § 8, p. 113; am. and redesign. 2003, ch. 96, § 12, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4910A.

Former § 41-4911A was amended and redesignated as § 41-4912A.

§ 41-4912. Storage tanks eligible for insurance. — (1) Eligible storage tanks are those tanks that meet all of the following criteria:

- (a) Appropriate fees required in [section 41-4909, Idaho Code](#), or [section 41-4911A, Idaho Code](#), have been paid;
- (b) The tank, if an underground storage tank, is in compliance with applicable federal and state underground storage tank rules and regulations;
- (c) The tank is used only for storage of petroleum products;
- (d) The tank, if an underground storage tank, passes a tank tightness test;
- (e) The tank, if an aboveground storage tank, is in compliance with state and federal rules and regulations including the international fire code. If an aboveground tank is exempt from state or federal rules and regulations and/or the international fire code by virtue of its being installed prior to the effective date of such rules and regulations or the international fire code, such tank is not eligible unless it passes a tank tightness test;
- (f) The tank, if a farm tank or residential tank, is in compliance with any applicable state or federal rules and regulations;
- (g) Any contamination caused by or released by or from the tank has been cleaned up, or a plan for cleanup or removal approved by the Idaho department of environmental quality, is being implemented; provided, however, that the trust fund shall not pay for any costs associated with prior contamination.

(2) Any tank which is a part of a refiner's terminal or a tank directly supplied by a pipeline shall not be eligible.

History.

[I.C., § 41-4911](#), as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 9, p. 113; am. 1996, ch. 425, § 1, p. 1452; am. 2001, ch. 103, § 77, p. 253; am. 2002, ch. 86, § 10, p. 195; am. and redesisg. 2003, ch. 96, § 13, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4911.

Former § 41-4912 was amended and redesignated as § 41-4913.

See [Idaho Administrative Code § 18.01.50](#) for adoption of 2015 international fire code.

§ 41-4912A. Storage tanks located on sites where contamination is present. — (1) Notwithstanding the provisions of [section 41-4912\(1\)\(g\), Idaho Code](#), an owner or operator of a petroleum storage tank or tanks located on a site where contamination is present may be eligible for insurance covering the petroleum storage tanks located on that site if the contamination does not pose a threat to public health, safety or the environment, or was not caused by or released by or from the tank, or if multiple tanks are present on the site, any one (1) of the tanks, for which insurance coverage is sought; provided, however, that the trust fund shall not pay for any corrective action costs or compensation to third parties for bodily injury or property damage arising from the prior contamination present at the site.

(2) Any contamination caused by or released by or from the tank or tanks which may migrate off-site; contaminate ground water; exceed federal or state standards, guidelines, criteria or contaminant levels for ground water or drinking water; or pose a fire, explosion or safety hazard may be deemed by the administrator to present a threat to public health, safety or the environment. An owner or operator of such petroleum storage tank or tanks will not be eligible for insurance covering the petroleum storage tanks located on that site unless the contamination has been cleaned up or a plan for cleanup or removal approved pursuant to [section 41-4912\(1\)\(g\), Idaho Code](#), is being implemented.

(3) Contracts of insurance issued to an owner or operator of a petroleum storage tank located on a site where contamination is present and where the administrator has determined that the contamination does not pose a threat to public health, safety or the environment, or was not caused by or released by or from the tank or tanks shall exclude from coverage corrective action costs and compensation to third parties for bodily injury or property damage arising out of the prior contamination present at the site.

History.

[I.C., § 41-4911A](#), as added by 1991, ch. 59, § 10, p. 113; am. 1996, ch. 425, § 2, p. 1452; am. and redesign. 2003, ch. 96, § 14, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4911A.

Effective Dates.

Section 3 of S.L. 1996, ch. 425 provided that the act shall be in full force and effect on July 1, 1997.

§ 41-4913. State treasurer custodian of trust fund — Duties. — The state treasurer shall be the custodian of the trust fund balance.

History.

I.C., § 41-4912, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 15, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4912.

Former § 41-4913 was amended and redesignated as § 41-4914.

§ 41-4914. Deposit and investment of funds — Interest. — The state treasurer shall deposit or, on order of the board of trustees of the trust fund, invest any portion of the Idaho petroleum clean water trust fund not needed for immediate or currently anticipated use, in the manner provided by law. Interest earned by such invested portion of the trust fund shall be collected by the state treasurer and placed to the credit of the trust fund.

History.

I.C., § 41-4913, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 16, p. 281; am. 2007, ch. 194, § 2, p. 570.

STATUTORY NOTES

Cross References.

State treasurer, § 67-1201 et seq.

Amendments.

The 2007 amendment, by ch. 194, substituted “board of trustees” for “administrator.”

Compiler’s Notes.

This section was formerly compiled as § 41-4913.

Former § 41-4914 was amended and redesignated as § 41-4915.

§ 41-4915. Perpetual appropriation. — All moneys which may come into the Idaho petroleum clean water trust fund are hereby perpetually appropriated to the trust fund for the purposes of this chapter.

History.

I.C., § 41-4914, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 17, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4914.

Former § 41-4915 was amended and redesignated as § 41-4916.

§ 41-4916. Enrolled subscribers' liability on judgment. — (1) No action shall lie against any owner or operator of a tank insured by the Idaho petroleum clean water trust fund upon any obligation claimed against this trust fund until a final judgment has been obtained against this trust fund and remains unsatisfied for thirty (30) days.

(2) Any such judgment shall be binding upon each owner or operator only in such proportion as his interests may appear and in an amount not exceeding his contingent liability, if any, in excess of the amount of insurance provided by the trust fund.

History.

I.C., § 41-4915, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 11, p. 113; am. and redesisg. 2003, ch. 96, § 18, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4915.

Former § 41-4916 was amended and redesignated as § 41-4917.

§ 41-4917. Actions for collection in case of default — Penalty — Cancellation of insurance contract. — (1) If an insured owner or operator of a storage tank shall default in any reimbursement required to be made by the insured to the trust fund under [section 41-4907, Idaho Code](#), the amount due from the insured may be collected by civil action against him in the name of the administrator, and the same, when collected by the administrator shall be paid into the trust fund, and such insured's compliance with the provisions of this chapter requiring payment to be made to the trust fund shall date from the time the money is collected by the administrator.

(2) The contract of insurance held by an insured owner or operator of a storage tank which fails to comply with [section 41-4912, Idaho Code](#), or who is in default in his enrollment fees for more than thirty (30) days may be canceled at the discretion of the administrator.

History.

[I.C., § 41-4916](#), as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 12, p. 113; am. and redesisg. 2003, ch. 96, § 19, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4916.

Former § 41-4917 was amended and redesignated as § 41-4918.

§ 41-4918. Cancellation of insurance. — Any insured owner or operator of a storage tank may cancel his insurance by returning his insurance contract to the administrator for cancellation. There shall be no refund of any application fees paid to the trust fund as all such fees shall be deemed fully earned when an insurance contract is issued or renewed.

History.

I.C., § 41-4917, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 13, p. 113; am. and redesign. 2003, ch. 96, § 20, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4917.

Former § 41-4918 was amended and redesignated as § 41-4919.

§ 41-4919. Reinsurance. — (1) The administrator of the trust fund may reinsure any risk, or any part thereof, and may enter into agreements of reinsurance in the same way and to the same extent as other insurance carriers, the cost of which shall be paid out of the trust fund balance.

(2) Such reinsurance contracts may be on a specific excess basis for each liability loss sustained, or on a quota share basis of each liability loss sustained, or on a treaty basis wherein a line of credit is available to pay losses in excess of a given amount with the money obtained from such a loan arrangement to be paid back only from expendable surplus funds, or on a facultative basis with one (1) or more reinsurers whereby successive portions of the loss are paid on a given share basis, and/or on a net annual aggregate stop loss basis whereby the reinsurer must contribute to all losses when such losses exceed a given amount in any policy year, or any other reinsurance agreement found to be necessary, prudent and reasonable by competent actuaries.

History.

I.C., § 41-4918, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 21, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4918.

Former § 41-4919 was amended and redesignated as § 41-4920.

§ 41-4920. Payments from the trust fund by state treasurer. — The administrator of the trust fund shall submit each month to the state board of examiners an estimate of the amount necessary to meet the current disbursements for liability insurance losses to be paid in behalf of insured owners or operators of the trust fund during each succeeding calendar month, and when such estimate shall be approved by the state board of examiners, the state treasurer is authorized to pay the same out of the fund upon sight drafts drawn by the administrator. At the end of each calendar month the administrator shall account to the state board of examiners and the board for all money so received, furnishing proper vouchers therefor.

History.

I.C., § 41-4919, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 14, p. 113; am. and redesisg. 2003, ch. 96, § 22, p. 281.

STATUTORY NOTES

Cross References.

State board of examiners, § 67-2001 et seq.

State treasurer, § 67-1201 et seq.

Compiler's Notes.

This section was formerly compiled as § 41-4919.

Former § 41-4920 was amended and redesignated as § 41-4921.

§ 41-4921. Reserve funds. — The Idaho petroleum clean water trust fund shall establish and maintain the following reserves or financial resources, which shall constitute liabilities in any determination of the financial condition of the trust fund:

(1) An amount sufficient for the payment of all claims made against the trust fund, which shall include reasonable estimates for claim adjustment expense, legal fees and other claim settlement costs, and including claims reported and not yet paid and claims incurred but not reported to the trust fund but only to the extent that a reasonable estimate can be made based on prior statistical evidence and the condition of storage tanks insured by the trust fund.

(2) An amount adequate under reasonable estimates for the payment of any unpaid contractual obligations, taxes and any other services and expenses incurred but not paid.

History.

I.C., § 41-4920, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 23, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4920.

Former § 41-4921 was amended and redesignated as § 41-4922.

§ 41-4922. Plan of operation. — The administrator shall establish a plan of operation to be approved by the director of the department of insurance for the state of Idaho.

History.

I.C., § 41-4921, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 15, p. 113; am. and redesign. 2003, ch. 96, § 24, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4921.

Former § 41-4922 was amended and redesignated as § 41-4923.

§ 41-4923. Registration of the trust fund. — The trust fund established pursuant to the provisions of this chapter shall be registered with the director as set out in this chapter.

History.

I.C., § 41-4922, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 25, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4922.

Former § 41-4923 was amended and redesignated as § 41-4924.

§ 41-4924. Qualifications for registration. — The director shall not register the trust fund if it is not qualified therefor. To be qualified, the trust fund:

(1) Shall require all application fees to be paid in advance and to be deposited in and disbursed from the trust fund duly created under this chapter.

(2) Shall have, or provide for, a trustworthy and responsible administrator for competent administration of the trust fund and plan.

(3) Shall provide that the administrator furnish to each insured owner or operator a contract of insurance adequately and clearly stating all rights and obligations of the insured owner or operator, together with all applicable restrictions, limitations and exclusions, and the procedure for filing a claim.

(4) Shall be actuarially sound; that is, assets, income and other financial resources of the trust fund must be adequate under reasonable estimates for payment of all claims, claims adjustment expenses, taxes, expenses and other obligations.

(5) Shall otherwise be in compliance with the provisions of this chapter.

History.

I.C., § 41-4923, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 16, p. 113; am. and redesisg. 2003, ch. 96, § 26, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4923.

Former § 41-4924 was amended and redesignated as § 41-4925.

§ 41-4925. Application for registration — Fee. — (1) Application for registration of the trust fund shall be made to the director, on forms furnished and designed by him for the purpose of eliciting information as to whether the trust fund is qualified for registration. The application shall be signed and verified by the board.

(2) The application shall be accompanied by: (a) A copy of the bylaws of the trust fund referred to in [section 41-4927, Idaho Code](#); (b) A copy of the proposed contract of insurance; (c) A written plan of operation that outlines the reasonably projected income and disbursements of the trust fund for the twelve (12) month period commencing with date of application and showing also the amount reserved and financial resources available as of the end of such period for claims incurred and not paid or incurred and not reported; (d) A current certified audited financial statement; (e) Such other relevant documentation and information as the director may reasonably require.

(3) A nonrefundable filing fee of twenty-five dollars (\$25.00) shall be paid to the director at the time the application is filed.

History.

[I.C., § 41-4924](#), as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 17, p. 113; am. and redesign. 2003, ch. 96, § 27, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4924.

Former § 41-4925 was amended and redesignated as § 41-4926.

§ 41-4925A. Amendments to plan of operation. — (1) Any amendment to the plan of operation prepared by the administrator for the purpose of deferring the issuance of contracts of insurance to any category of petroleum storage tank owners or operators or for issuing contracts of insurance to any deferred category of petroleum storage tank owners or operators shall be submitted to the director of the department of insurance.

(2) The director shall review the amendment and shall, with all reasonable promptness, approve, approve as modified, or disapprove of the amendment to the plan of operation. If the amendment is approved, the administrator may issue contracts of insurance and otherwise operate the trust fund in a manner consistent with the amended plan of operation. If the amendment is disapproved, the administrator must operate the trust fund in a manner consistent with the provisions of the plan of operation as submitted to the director in the trust fund's application for registration under [section 41-4925, Idaho Code](#).

(3) The director may request such relevant documentation and information, including an actuarial analysis of the underwriting capacity of the trust fund, as is reasonably necessary to evaluate the proposed amendment to the plan of operation.

(4) All procedures and policies concerning the approval, modification or disapproval of any amendment to the plan of operation are subject to the provisions of chapter 52, title 67, Idaho Code, as well as the rules of practice and procedure of the department of insurance.

History.

[I.C., § 41-4924A](#), as added by 1991, ch. 59, § 18, p. 113; am. and redesign. 2003, ch. 96, § 28, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4924A.

§ 41-4926. Grant or denial of registration. — (1) The director shall act upon an application for registration of the trust fund with all reasonable promptness. He may make such investigation of the proposal as he deems advisable. If the director finds that the application is complete and that the plan meets the qualifications stated in [section 41-4924, Idaho Code](#), he shall issue and deliver a certificate of registration in appropriate form to the applicant; otherwise, the director shall refuse to register the plan and shall give written notice of such refusal to the applicant, stating the reasons therefor.

(2) All procedures and policies concerning the grant or denial of registration of the trust fund are subject to the provisions of chapter 52, title 67, Idaho Code, as well as the rules of practice and procedure of the department of insurance.

History.

[I.C., § 41-4925](#), as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 19, p. 113; am. and redesisg. 2003, ch. 96, § 30, p. 281.

STATUTORY NOTES

Prior Laws.

Former § 41-4926, which comprised [I.C., § 41-4926](#), as added by 1990, ch. 119, § 1, p. 266, was repealed by S.L. 2003, ch. 96, § 29, effective July 1, 2003.

Compiler's Notes.

This section was formerly compiled as § 41-4925.

§ 41-4927. Bylaws of the fund. — The board shall adopt bylaws subject to the approval of the director, who shall grant his approval only after his determination that the provisions in the bylaws are not inconsistent nor contrary to the applicable provisions of title 41, Idaho Code, as amended in this chapter. These bylaws shall outline the organizational structure of the trust fund, its operational methods of complying with the provisions of this chapter, including the deposit, custody, disbursement and accounting for the moneys in the trust fund, fidelity bonds, if any, required of the administrator, the essential elements of the managerial contract with the administrator, the powers and duties of the administrator of the trust fund, the rights, privileges and responsibilities of insured owners or operators of storage tanks, the manner in which annual and special meetings of the board shall be conducted, and such other matters as may be customary, necessary or convenient for the management and operation of the trust fund.

History.

I.C., § 41-4930, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 21, p. 113; am. and redesign. 2003, ch. 96, § 31, p. 281.

STATUTORY NOTES

Prior Laws.

Former § 41-4927 was repealed by S.L. 1991, ch. 59, § 20, effective March 21, 1991.

Compiler's Notes.

This section was formerly compiled as § 41-4930.

§ 41-4928. Records and accounts — Annual statement. — (1) The administrator shall cause full and accurate records and accounts to be entered and maintained covering all financial transactions and affairs of the trust fund.

(2) Within sixty (60) days after the close of each calendar year, the administrator shall make an annual statement in writing summarizing the financial transactions of the trust fund for such prior calendar year and its financial condition at the end of such year in accordance with this chapter and generally accepted and applicable accounting principles. The statement shall otherwise be in the form prescribed and shall provide the information required by the director of the department of insurance of the state of Idaho, and the financial information contained therein shall be certified by the accountant by whom such information was prepared and audited.

(3) On or before the expiration of such sixty (60) day period the administrator shall cause an original of the annual statement to be filed with the director, and shall pay any filing fee required by the director or any other state agency having jurisdiction. At an appropriate time, consistent with the usual practices of the director, the director shall declare the annual statement to be open to the scrutiny of all interested parties and the public in general.

History.

I.C., § 41-4931, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 32, p. 281.

STATUTORY NOTES

Prior Laws.

Former § 41-4928 was repealed by S.L. 1991, ch. 59, § 20, effective March 21, 1991.

Compiler's Notes.

This section was formerly compiled as § 41-4931.

§ 41-4929. Management contract with the administrator — Mandatory provisions. — (1) The management contract entered into between the administrator and the board as required in this chapter, shall not become effective unless the contract is filed with and approved by the director. The contract shall be deemed approved unless disapproved by the director within twenty (20) days after date of filing, subject to such reasonable extension of time as the director may require by notice given within the twenty (20) day period. Any disapproval shall be delivered to the administrator in writing, stating the grounds therefor.

(2) Any such contract, or contract holder, shall provide that the administrator shall, within ninety (90) days after expiration of each calendar year, furnish the director a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, including the emoluments received therefrom by the principal management personnel of the administrator involved with the affairs of the trust fund, and with such classification of items and further detail as the director may reasonably require.

(3) The director shall disapprove any such contract if he finds that it: (a) Subjects the trust fund to unreasonable or excessive charges; or (b) Does not contain fair and adequate standards of performance; or (c) Contains other inequitable provisions which impair the proper interests of the owners or operators insured by the trust fund.

(4) The director may, after a hearing held thereon, withdraw his approval of any such contract theretofore approved by him, if he finds that the basis of his original approval no longer exists, or that the contract has, in actual operation, shown itself to be subject to disapproval on any of the grounds referred to in subsection (3) of this section.

History.

I.C., § 41-4932, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 22, p. 113; am. and redesign. 2003, ch. 96, § 33, p. 281.

STATUTORY NOTES

Prior Laws.

Former § 41-4929 was repealed by S.L. 1991, ch. 59, § 20, effective March 21, 1991.

Compiler's Notes.

This section was formerly compiled as § 41-4932.

§ 41-4930. Existing insurance laws to apply to the trust fund with certain exceptions. — The trust fund shall comply with all of the applicable provisions of title 41, Idaho Code, with certain exceptions as follows:

(1) The creation of the trust fund by act of the legislature shall not be deemed to be an ownership, control or operation of an insurer by a governmental entity, as referred to in [section 41-309, Idaho Code](#), and the surplus funds of the trust fund shall be considered to be dedicated and held in reserve for the purpose of providing funds for the payment of claims arising out of the discharge of petroleum products from tanks covered by a contract of insurance issued to the tank owner or operator by the trust fund as provided for in [section 41-4906, Idaho Code](#). The absolute control of the trust fund shall be vested in the board.

(2) The provisions of this chapter shall be construed to be contained in the document of organization and bylaws of the trust fund for purposes of sections 41-319, 41-320 and 41-322, Idaho Code, and the director shall issue a certificate of registration to and in the name of the trust fund upon his finding that it has met all other appropriate provisions of the Idaho Code, including sections 41-313, 41-316 and 41-316A, Idaho Code.

(3) [Section 41-337, Idaho Code](#), shall not apply to contracts of insurance issued by the trust fund.

(4) Sections 41-1004 and 41-1022, Idaho Code, shall not apply to employees of the state insurance fund or the trust fund.

(5) [Section 41-1103, Idaho Code](#), shall not apply to employees of the state insurance fund or the trust fund, provided the employees restrict their claims adjusting and investigation operations only to those contracts issued by the trust fund.

(6) Except as otherwise provided in this chapter, chapter 28, title 41, Idaho Code, and chapter 14, title 30, Idaho Code, shall not apply to the trust fund nor shall this trust fund be construed to be a domestic mutual insurer, nor a reciprocal insurer, nor any other type of insurer currently regulated by

title 41, Idaho Code, and the only organizational requirements of this trust fund shall be those enumerated in this chapter.

History.

I.C., § 41-4933, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 23, p. 113; am. 1994, ch. 240, § 12, p. 751; am. 2001, ch. 296, § 9, p. 1044; am. and redesign. 2003, ch. 96, § 34, p. 281.

STATUTORY NOTES

Cross References.

State insurance fund, § 72-901 et seq.

Compiler's Notes.

This section was formerly compiled as § 41-4933.

Former § 41-4930 was amended and redesignated as § 41-4927.

Section 13 of S.L. 1994, ch. 240 read: “Nothing contained in the provisions of this act is intended or shall repeal Section 36 of Chapter 194, Laws of 1993.” Section 36 of S.L. 1993, ch. 194 provided, “For a period of twenty-four (24) months after the effective date of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

Effective Dates.

Section 14 of S.L. 1994, ch. 240 declared an emergency. Approved March 30, 1994.

§ 41-4931. Taxes. — (1) The trust fund shall not be subject to chapter 4, title 41, Idaho Code, as it pertains to premium tax.

(2) The state of Idaho hereby preempts the field of imposing excise, privilege, franchise, income, license and similar taxes, licenses and fees upon the trust fund; and no county, city, municipality, district, school district, or other political subdivision or agency of Idaho shall levy upon this trust fund any such tax, license or fee.

History.

I.C., § 41-4934, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 35, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4934.

Former § 41-4931 was amended and redesignated as § 41-4928.

§ 41-4932. Examination of books, records and accounts. — (1) The books, records, accounts and affairs of the trust fund shall be subject to examination by the director by competent examiners duly authorized by him in writing, at such times or intervals as the director deems advisable. The purposes of the examination shall be to determine compliance of the trust fund with applicable laws, the financial condition and actuarial adequacy of the trust fund, and other factors materially related to the trust fund's management and operation.

(2) The administrator shall make the books, records and accounts of the trust fund available to the examiner and otherwise facilitate the examination.

(3) The examiner shall conduct the examination expeditiously, make his report of the examination in writing, and deliver a copy thereof to the administrator and the director. The administrator shall have two (2) weeks after receipt of the report within which to recommend to the director such corrections or changes therein as the administrator may deem appropriate. After making such corrections or changes, if any, as he deems proper, the director shall file the report in his office as a document open to public inspection, and deliver to the administrator a copy of the report as so corrected or changed.

(4) At the direction of the director, the costs of the examination shall be borne by the trust fund in accordance with [section 41-228, Idaho Code](#).

History.

[I.C., § 41-4935](#), as added by 1990, ch. 119, § 1, p. 266; am. 2001, ch. 85, § 13, p. 211; am. and redesisg. 2003, ch. 96, § 36, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4935.

Former § 41-4932 was amended and redesignated as § 41-4929.

§ 41-4933. Administrator — Fidelity bonds. — The administrator shall cause all individuals handling receipts and disbursements for the trust fund to be bonded at all times under a fidelity bond issued by a surety insurer authorized to transact such insurance in this state. The bond shall be in favor of the trust fund and for such aggregate penalty amount, not less than twenty-five thousand dollars (\$25,000), as the director may deem reasonably advisable in relation to the amount of funds to be so handled. The bond shall be noncancelable except upon not less than thirty (30) days advance notice in writing to the administrator and the director. The cost of the bond shall be borne by the trust fund.

History.

I.C., § 41-4936, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 37, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4936.

Former § 41-4933 was amended and redesignated as § 41-4930.

§ 41-4934. Prohibited pecuniary interests in plan management. — (1) Neither the administrator nor any other person having responsibility for the management of the trust fund or the investment or other handling of the trust fund moneys or assets shall:

(a) Receive directly or indirectly or be pecuniarily interested in any fee, commission, compensation or emolument, other than salary or other similar compensation regularly fixed and allowed for services regularly rendered to the trust fund, arising out of any transaction to which the trust fund is or is to be a party;

(b) Receive compensation as a consultant to the trust fund while also acting as a trustee or administrator, or as an employee of either;

(c) Have any direct or indirect material pecuniary interest in any loan or investment of the trust fund.

(2) The director may, after reasonable notice and a hearing, prohibit the administrator from employing or retaining or continuing to employ or retain any person in the administration of the trust fund upon finding that such employment or retention involves a conflict of interest not in the best interests of the trust fund or adversely affecting the interests of the owners or operators insured by the trust fund.

(3) Any conflict of interest or prohibited pecuniary interest involving the members of the board of trustees of the trust fund shall be governed solely by the conflict of interest provisions of the Idaho nonprofit corporation act as set forth in [section 30-30-619, Idaho Code](#).

History.

[I.C., § 41-4937](#), as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 24, p. 113; am. and redesign. 2003, ch. 96, § 38, p. 281; am. 2004, ch. 175, § 2, p. 552; am. 2017, ch. 58, § 27, p. 91.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 58, substituted “[section 30-30-619, Idaho Code](#)” for “[section 30-3-81, Idaho Code](#)” at the end of subsection (3).

Compiler’s Notes.

This section was formerly compiled as § 41-4937.

Former § 41-4934 was amended and redesignated as § 41-4931.

§ 41-4935. Political contributions prohibited. — The administrator shall not make or knowingly permit the making, directly or indirectly, of any political contribution by or from the trust fund.

History.

I.C., § 41-4938, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 39, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4938.

Former § 41-4935 was amended and redesignated as § 41-4932.

§ 41-4936. Recovery of depleted funds. — If after notice and hearing, the director finds that the trust fund has been depleted by reason of any wrongful or negligent act or omission of the board or any other person, he shall transmit a copy of his findings to the attorney general of this state, who may bring an action in the name of the people of this state, or intervene in any action brought by or on behalf of an insured owner or operator for the recovery of the amount of such depletion, for the benefit of the trust fund.

History.

I.C., § 41-4939, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 25, p. 113; am. and redesign. 2003, ch. 96, § 40, p. 281.

STATUTORY NOTES

Cross References.

Attorney general, § 67-1401 et seq.

Compiler's Notes.

This section was formerly compiled as § 41-4939.

Former § 41-4936 was amended and redesignated as § 41-4933.

§ 41-4937. Impaired trust fund. — (1) If the assets of the trust fund are at any time insufficient to discharge its liabilities, and to maintain the required surplus, the administrator shall forthwith request authority from the director to make up the deficiency by borrowed surplus or other subordinated indebtedness.

(2) If the director finds that future estimated revenues from the transfer fees imposed under [section 41-4909, Idaho Code](#), are not sufficient to justify any borrowed surplus funds or other subordinated indebtedness, then the director shall request the administrator to submit a plan of action whereby priority is given to the payment of cleanup costs of petroleum discharges that constitute a clear and present danger to persons or property, including discharges into underground or surface water that may seriously contaminate the water used for domestic and commercial use, agricultural products, livestock, fish, game and other wildlife. Consideration shall be given in this plan of action to establishing a claim payment priority based on the severity of the contamination, the possible endangerment of life and health including, but not limited to, possible toxic fumes, fire and explosion hazards, economic impact, population density, and the need for immediate cleanup action versus action that can be delayed with only minimal adverse effects. This plan of action shall also establish similar criteria for the prioritization of the payment of bodily injury and property damage claims.

(3) Upon receiving this plan of action, the director shall promptly hold a public hearing with appropriate notice to determine any possible adverse effects of the plan of action on the owners or operators of insured tanks, the claimants and potential claimants, and the environment. After giving due consideration to the testimony of those parties affected by the proposed plan of action, the director shall either approve or disapprove the plan in writing, stating the reasons therefor, so that a plan of action that does meet with the director's approval can be placed into effect with due diligence and dispatch.

(4) Upon receiving the director's approval of the plan of action, the administrator shall promptly commence the prioritization of claims and pay

such valid and compensable claims according to this priority as funds become available from collection of the transfer fees.

History.

I.C., § 41-4940, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 26, p. 113; am. and redesign. 2003, ch. 96, § 41, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4940.

Former § 41-4937 was amended and redesignated as § 41-4934.

§ 41-4938. Liquidation of trust fund. — (1) The annual tank application fees and transfer fees are perpetually appropriated as dedicated funds for the purposes of this chapter, and the trust fund shall remain in existence as long as the need exists for the trust fund to insure the costs of corrective actions and the need exists for the trust fund to insure the legal liability of petroleum tank owners and operators as provided in this chapter.

(2) In the event other more appropriate means come into existence to provide the insurance provided by the trust fund, then the trust fund shall be liquidated according to the provisions of this section.

(3) Liquidation shall be conducted by the board under a written plan of liquidation filed with and approved by the director. If the director finds the plan to be fair and equitable to all persons having a pecuniary interest in the trust fund, he shall approve it. Any balance remaining after payment or adequate provision for payment of all claims and charges against the trust fund has been made shall be disposed of in the manner provided for in the plan of liquidation. Unless under the plan of liquidation the liability for all unpaid claims and obligations of the trust fund has been assumed by another financially responsible person or persons, the existence of surplus funds for such disposition shall not be determined prior to the expiration of two (2) years after termination of the certificate of registration issued to the trust fund as provided in [section 41-4930\(2\), Idaho Code](#).

(4) After its approval by the director, the plan of liquidation for the trust fund shall be binding upon all persons pecuniarily interested in the trust fund. Pending the effectuation of the plan of liquidation the director may impose such prohibitions or restrictions upon disbursement or use of trust fund moneys as the director deems advisable for the protection of all interested persons.

(5) If the trust fund is then insolvent and a plan of liquidation thereof satisfactory to the director as being fair and equitable is not filed within sixty (60) days after the effective date of termination of the plan's registration, or if liquidation of a solvent trust fund is not being carried out in accordance with the plan of liquidation theretofore approved by the director, the director shall liquidate the trust fund under the applicable

provisions of chapter 33, title 41, Idaho Code, and for this purpose the trust fund shall be deemed to be an insolvent domestic insurer.

(6) If after all indebtedness and other obligations of the trust fund are discharged to the satisfaction of the director and the trust fund is dissolved, its remaining assets, if any, shall inure to the benefit of the state.

History.

I.C., § 41-4941, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 27, p. 113; am. and redesign. 2003, ch. 96, § 42, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4941.

Former § 41-4938 was amended and redesignated as § 41-4935.

§ 41-4939. Vouchers for expenditures. — (1) The administrator of the trust fund shall not make any disbursement of twenty-five dollars (\$25.00) or more, unless evidenced by a voucher or other document correctly describing the consideration for the payment and supported by a check or receipt endorsed or signed by or on behalf of the person receiving the money.

(2) If the disbursement is for services and reimbursement, the voucher or other document, or some other writing referred to therein, shall describe the services and itemize the expenditures.

(3) If the disbursement is in connection with any matter pending before any legislature or public body or before any public official, the voucher or other document shall also correctly describe the nature of the matter and of the trust fund's interest therein.

History.

I.C., § 41-4942, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 43, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4942.

Former § 41-4939 was amended and redesignated as § 41-4936.

§ 41-4940. Borrowed surplus and subordinated indebtedness. — (1) The trust fund may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the trust fund's surplus in excess of the amount stipulated in such agreement. The agreement may provide for interest, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess or surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan.

(2) Money so borrowed, together with the interest thereon, if so stipulated in the agreement, shall not form a part of the fund's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement, or be the basis of any setoff, but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(3) Any such loan shall be subject to the approval of the director. The trust fund shall, in advance of the loan, file with the director a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within fifteen (15) days after the date of such filing, the trust fund is notified of the director's disapproval and the reasons therefor. The director shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended, or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the trust fund, or that the information so filed by the trust fund is inadequate.

(4) Any such loan to the trust fund or substantial portion thereof shall be repaid by the trust fund when no longer reasonably necessary for the purpose originally intended. No repayment of such a loan shall be made by the fund unless approved in advance by the director.

(5) In the event of liquidation, repayment of the balance of the borrowed funds and any accrued interest then due and owing shall be paid only out of assets remaining after the payment of all obligations and claims of owners

or operators of petroleum tanks insured by the trust fund and general creditors.

(6) The provisions of this section shall not apply to loans obtained by the trust fund in ordinary course of business from banks and other financial institutions, nor to loans secured by pledge or mortgage of assets.

History.

I.C., § 41-4943, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 28, p. 113; am. and redesign. 2003, ch. 96, § 44, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4943.

Former § 41-4940 was amended and redesignated as § 41-4937.

§ 41-4941. Penalties. — (1) Any person who willfully violates or causes or induces a violation of any provision of this chapter or any lawful rule of the director issued thereunder, shall be subject to penalty as provided in subsection (4) of this section.

(2) Any person who makes a false statement or representation of a material fact, knowing it to be false, or who knowingly fails to disclose a material fact in any application, examination, or statement required under this act or by lawful rule of the director thereunder, shall be subject to penalty as provided in subsection (4) of this section.

(3) Any person who makes a false entry in any book, record, statement, or report required in this chapter or lawful rule of the director thereunder to be kept by him, with intent to injure or defraud the trust fund or any member thereof, or to deceive anyone authorized or entitled to examine the affairs of the trust fund, shall be subject to penalty as provided in subsection (4) of this section.

(4) For each such violation, act or omission referred to in this section, unless greater penalty is provided therefor under any other applicable law, the offender shall upon conviction thereof be subject to a fine of not more than one thousand dollars (\$1,000) and to imprisonment for not more than one (1) year, or to both such fine and imprisonment.

History.

I.C., § 41-4944, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 45, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4944.

Former § 41-4941 was amended and redesignated as § 41-4938.

The term “this act” in subsection (2) refers to S.L. 1990, Chapter 119, which is codified as §§ 41-4901 to 41-4903, 41-4905 to 41-4910, 41-4911,

41-4912, 41-4913 to 41-4925, and 41-4926 to 41-4944.

§ 41-4942. Rules — Director — Department of insurance. — (1) The director may make reasonable rules necessary as an aid to the effectuation of any provision of this chapter. No such rule shall extend, modify or conflict with any provision of this chapter and the reasonable implications thereof.

(2) Such rules, or any amendment thereof, shall be made by the director only after a public hearing thereon of which the director has given written notice not less than thirty (30) days in advance to the board of the trust fund then registered with him. If reasonably possible the director shall include with the notice a copy of the proposed rules or amendment, or a condensed summary of material proposed provisions.

(3) All procedures and policies concerning the promulgation of such rules, or any amendment thereof, are subject to the provisions of chapter 52, title 67, Idaho Code, and the rules of practice and procedure of the department of insurance.

History.

I.C., § 41-4945, as added by 1990, ch. 119, § 1, p. 266; am. and redesign. 2003, ch. 96, § 46, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4945.

Former § 41-4942 was amended and redesignated as § 41-4939.

§ 41-4943. Application of chapter. — All of the provisions of this chapter shall apply to and confer all rights, privileges, exemptions and immunities upon the trust fund established for the purposes contemplated in this chapter, and the administrator, insured owners or operators of petroleum tanks, beneficiaries, and participants thereof. The provisions of this chapter shall not apply to any railroad, railroad corporation, or any employee thereof when such employee is acting in the course of his employment for any such railroad or railroad corporation.

History.

I.C., § 41-4946, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 29, p. 113; am. and redesisg. 2003, ch. 96, § 47, p. 281.

STATUTORY NOTES

Compiler's Notes.

This section was formerly compiled as § 41-4946.

Former § 41-4943 was amended and redesignated as § 41-4940.

§ 41-4944. Insurance. — The coverage provided by the trust fund established pursuant to this chapter shall be deemed insurance for the purposes of any requirements of the Idaho department of environmental quality concerning the financial responsibility of owners or operators of petroleum storage tanks.

History.

I.C., § 41-4947, as added by 1990, ch. 119, § 1, p. 266; am. 1991, ch. 59, § 30, p. 113; am. 2001, ch. 103, § 78, p. 253; am. and redesign. 2003, ch. 96, § 48, p. 281.

STATUTORY NOTES

Cross References.

Department of environmental quality created, § 39-104.

Compiler's Notes.

This section was formerly compiled as § 41-4947.

Former § 41-4944 was amended and redesignated as § 41-4941.

Effective Dates.

Section 31 of S.L. 1991, ch. 59 declared an emergency. Approved March 21, 1991.

§ 41-4945. Personal liability. — The board and the administrator shall not, nor shall any person employed by them, be personally liable in a private capacity for or on account of any act performed or contract entered into in good faith and without the intent to defraud, in connection with the administration of the fund or affairs relating thereto.

History.

I.C., § 41-4945, as added by 2003, ch. 96, § 50, p. 281; am. 2004, ch. 175, § 3, p. 552.

STATUTORY NOTES

Compiler's Notes.

Former § 41-4945 was amended and redesignated as § 41-4942.

§ 41-4946. Actions against the fund, the board, its employees, and administrator subject to the Idaho tort claims act. — Any action against the fund, the board, its employees, and the administrator shall be subject in full to the Idaho tort claims act under chapter 9, title 6, Idaho Code.

History.

I.C., § 41-4946, as added by 2003, ch. 96, § 51, p. 281; am. 2004, ch. 175, § 4, p. 552.

STATUTORY NOTES

Compiler's Notes.

Former § 41-4946 was amended and redesignated as § 41-4943.

§ 41-4948. Legislative review of program. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-4948, as added by 1990, ch. 119, § 1, p. 266, was repealed by S.L. 2003, ch. 96, § 49.

Chapter 50
UNDERGROUND STORAGE TANK UPGRADE ASSISTANCE
PROGRAM

Sec.

41-5001 — 41-5006. [Repealed.]

§ 41-5001 — 41-5006. Underground storage tank upgrade assistance program. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 1993, ch. 310, § 1, effective March 31, 1993: 41-5001. (I.C., § 41-5001, as added by 1991, ch. 336, § 1, p. 870; am. 1993, ch. 163, § 1).

41-5002. (I.C., § 41-5002, as added by 1991, ch. 336, § 1, p. 870).

41-5003. (I.C., § 41-5003, as added by 1991, ch. 336, § 1, p. 870).

41-5004. (I.C., § 41-5004, as added by 1991, ch. 336, § 1, p. 870).

41-5005. (I.C., § 41-5005, as added by 1991, ch. 336, § 1, p. 870; am. 1993, ch. 163, § 2).

41-5006. (I.C., § 41-5006, as added by 1991, ch. 336, § 1, p. 870; am. 1993, ch. 163, § 3).

Chapter 51

REINSURANCE INTERMEDIARY ACT

Sec.

41-5101. Short title.

41-5102. Definitions.

41-5103. Licensure.

41-5104. Required contract provisions — Reinsurance intermediary — Brokers.

41-5105. Books and records — Reinsurance intermediary brokers.

41-5106. Duties of insurers utilizing the services of a reinsurance intermediary — Broker.

41-5107. Required contract provisions — Reinsurance intermediary — Managers.

41-5108. Prohibited acts.

41-5109. Duties of reinsurers utilizing the services of a reinsurance intermediary — Manager.

41-5110. Examination authority.

41-5111. Penalties and liabilities.

Idaho Code § 41-5101

§ 41-5101. Short title. — This chapter may be cited as the “Reinsurance Intermediary Act.”

History.

I.C., § 41-5101, as added by 1992, ch. 82, § 1, p. 248.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer. **87 A.L.R.6th 319**.

§ 41-5102. Definitions. — As used in this chapter:

(1) “Actuary” means a person who is a member in good standing of the American academy of actuaries.

(2) “Controlling person” means any person, firm, association or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control or activities of the reinsurance intermediary.

(3) “Insurer” means any person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer.

(4) “Licensed producer” means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provision of the insurance law.

(5) “Qualified United States financial institution” means for purposes of this chapter, a qualified United States financial institution that:

(a) Is organized or, in the case of a United States office of a foreign banking organization, licensed, under the laws of the United States or any state thereof;

(b) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(c) Has been determined by either the director, or the securities valuation office of the national association of insurance commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the director.

(6) “Reinsurance intermediary” means a reinsurance intermediary-broker, or a reinsurance intermediary-manager as these terms are defined in subsections (7) and (8) of this section.

(7) “Reinsurance intermediary-broker (RB)” means any person, other than an officer or employee of the ceding insurer, firm, association or corporation who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

(8) “Reinsurance intermediary-manager (RM)” means any person, firm, association or corporation who has authority to bind or manage all or part of the assumed reinsurance business of a reinsurer (including the management of a separate division, department or underwriting office) and acts as an agent for such reinsurer whether known as a RM, manager or other similar term. Notwithstanding the above, the following persons shall not be considered a RM, with respect to such reinsurer, for the purposes of this chapter:

(a) An employee of the reinsurer;

(b) A United States manager of the United States branch of an alien reinsurer;

(c) An underwriting manager which, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to chapter 38, title 41, Idaho Code, and whose compensation is not based on the volume of premiums written; or

(d) The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and which are subject to examination by the insurance director of the state in which the manager’s principal business office is located.

(9) “Reinsurer” means any person, firm, association or corporation duly licensed or authorized to do business in this state pursuant to the applicable provisions of the insurance law as an insurer with the authority to assume reinsurance.

(10) “To be in violation” means that the reinsurance intermediary, insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provision of this chapter.

History.

I.C., § 41-5102, as added by 1992, ch. 82, § 1, p. 248.

STATUTORY NOTES

Compiler's Notes.

For American academy of actuaries, referred to in subsection (1), see *<http://www.actuary.org>*.

For securities valuation office of the national association of insurance commissioners, referred to in paragraph (5)(c), see *<http://www.naic.org/svo.htm>*.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-5103. Licensure. — (1) No person, firm, association or corporation shall act as a RB in this state if the RB maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

(a) In this state, unless such RB is a licensed producer in this state; or

(b) In another state, unless such RB is a licensed producer in this state or another state having a law substantially similar to this law or such RB is licensed in this state as a nonresident reinsurance intermediary.

(2) No person, firm, association or corporation shall act as a RM:

(a) For a reinsurer domiciled in this state, unless such RM is a licensed producer in this state;

(b) In this state, if the RM maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this state, unless such RM is a licensed producer in this state;

(c) In another state for a nondomestic insurer, unless such RM is a licensed producer in this state or another state having a law substantially similar to this law or such person is licensed in this state as a nonresident reinsurance intermediary.

(3) The director may require a RM subject to subsection (2) of this section to:

(a) File a bond in an amount from an insurer acceptable to the director for the protection of the reinsurer; and

(b) Maintain an errors and omissions policy in an amount acceptable to the director.

(4)(a) The director may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of this chapter. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the

license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(b) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate the director as agent for service of process in the manner, and with the same legal effect, provided for in this title for designation of service of process upon unauthorized insurers, and shall also furnish the director with the name and address of a resident of this state upon whom notices or orders of the director or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall promptly notify the director in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the director.

(5) The director may refuse to issue a reinsurance intermediary license if, in his judgment, the applicant, anyone named on the application, or any member, principal, officer or director of the applicant, is not trustworthy, or that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the director will furnish a summary of the basis for refusal to issue a license, which document shall be privileged and exempt from disclosure pursuant to exemptions provided in chapter 1, title 74, Idaho Code.

(6) Licensed attorneys at law of this state when acting in their professional capacity as such shall be exempt from the provisions of this section.

History.

I.C., § 41-5103, as added by 1992, ch. 82, § 1, p. 248; am. 1999, ch. 30, § 12, p. 41; am. 2015, ch. 141, § 115, p. 379.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in the last sentence of subsection (5).

§ 41-5104. Required contract provisions — Reinsurance intermediary — Brokers. — Transactions between a RB and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

- (1) The insurer may terminate the RB's authority at any time.
- (2) The RB will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing, to the RB, and remit all funds due to the insurer within thirty (30) days of receipt.
- (3) All funds collected for the insurer's account will be held by the RB in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein.
- (4) The RB will comply with the provisions of [section 41-5105, Idaho Code](#).
- (5) The RB will comply with the written standards established by the insurer for the cession or retrocession of all risks.
- (6) The RB will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

History.

[I.C., § 41-5104](#), as added by 1992, ch. 82, § 1, p. 248.

§ 41-5105. Books and records — Reinsurance intermediary brokers.

— (1) For at least ten (10) years after expiration of each contract of reinsurance transacted by the RB, the RB will keep a complete record for each transaction showing:

(a) The type of contract, limits, underwriting restrictions, classes or risks and territory; (b) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation; (c) Reporting and settlement requirements of balances; (d) Rate used to compute the reinsurance premium;

(e) Names and addresses of assuming reinsurers;

(f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RB; (g) Related correspondence and memoranda;

(h) Proof of placement;

(i) Details regarding retrocessions handled by the RB including the identity of retrocessionaires and percentage of each contract assumed or ceded; (j) Financial records including, but not limited to, premium and loss accounts; and (k) When the RB procures a reinsurance contract on behalf of a licensed ceding insurer: (i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or (ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(2) The insurer will have access and the right to copy and audit all accounts and records maintained by the RB related to its business in a form usable by the insurer.

History.

I.C., § 41-5105, as added by 1992, ch. 82, § 1, p. 248.

§ 41-5106. Duties of insurers utilizing the services of a reinsurance intermediary — Broker. — (1) An insurer shall not engage the services of any person, firm, association or corporation to act as a RB on its behalf unless such person is licensed as required in [section 41-5103\(1\), Idaho Code](#).

(2) An insurer may not employ an individual who is employed by a RB with which it transacts business, unless such RB is under common control with the insurer and subject to the provisions of chapter 38, title 41, Idaho Code.

(3) The insurer shall annually obtain a copy of the statement of the financial condition of each RB with which it transacts business.

History.

[I.C., § 41-5106](#), as added by 1992, ch. 82, § 1, p. 248.

§ 41-5107. Required contract provisions — Reinsurance intermediary — Managers. — Transactions between a RM and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least thirty (30) days before such reinsurer assumes or cedes business through such producer, a true copy of the approved contract shall be filed with the director for approval. The contract shall, at a minimum, contain provisions that:

(1) The reinsurer may terminate the contract for cause upon written notice to the RM. The reinsurer may immediately suspend the authority of the RM to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The RM will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the RM, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(3) All funds collected for the reinsurer's account will be held by the RM in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein. The RM may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses. The RM shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least ten (10) years after expiration of each contract of reinsurance transacted by the RM, the RM will keep a complete record for each transaction showing:

- (a) The type of contract, limits, underwriting restrictions, classes or risks and territory;
- (b) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;
- (c) Reporting and settlement requirements of balances;

- (d) Rate used to compute the reinsurance premium;
- (e) Names and addresses of reinsurers;
- (f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the RM;
- (g) Related correspondence and memoranda;
- (h) Proof of placement;
- (i) Details regarding retrocessions handled by the RM, as permitted under the provisions of [section 41-5109\(4\), Idaho Code](#), including the identity of retrocessionaires and percentage of each contract assumed or ceded;
- (j) Financial records including, but not limited to, premium and loss accounts; and
- (k) When the RM places a reinsurance contract on behalf of a ceding insurer:

- (i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or
 - (ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the RM related to its business in a form usable by the reinsurer.

(6) The contract cannot be assigned in whole or in part by the RM.

(7) The RM will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

(8) Set forth the rates, terms and purposes of commissions, charges and other fees which the RM may levy against the reinsurer.

(9) If the contract permits the RM to settle claims on behalf of the reinsurer:

- (a) All claims will be reported to the reinsurer in a timely manner;

(b) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

- (i) Has the potential to exceed the lesser of an amount determined by the director or the limit set by the reinsurer;
- (ii) Involves a coverage dispute;
- (iii) May exceed the RM's claims settlement authority;
- (iv) Is open for more than six (6) months; or
- (v) Is closed by payment of the lesser of an amount set by the director or an amount set by the reinsurer;

(c) All claim files will be the joint property of the reinsurer and the RM. However, upon an order of liquidation of the reinsurer such files shall become the sole property of the reinsurer or its estate. The RM shall have reasonable access to and the right to copy the files on a timely basis; and

(d) Any settlement authority granted to the RM may be terminated for cause upon the reinsurer's written notice to the RM or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the RM, such interim profits will not be paid until one (1) year after the end of each underwriting period for property business and five (5) years after the end of each underwriting period for casualty business (or a later period set by the director for specified lines of insurance) and not until the adequacy of reserves on remaining claims has been verified pursuant to [section 41-5109\(3\), Idaho Code](#).

(11) The RM will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(12) The reinsurer shall periodically (at least semiannually) conduct an onsite review of the underwriting and claims processing operations of the RM.

(13) The RM will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer

pursuant to this contract.

(14) Within the scope of its actual or apparent authority the acts of the RM shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

History.

I.C., § 41-5107, as added by 1992, ch. 82, § 1, p. 248.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-5108. Prohibited acts. — The RM shall not:

(1) Cede retrocessions on behalf of the reinsurer, except that the RM may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(2) Commit the reinsurer to participate in reinsurance syndicates.

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed.

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one per cent (1%) of the reinsurer's policyholder surplus as of December 31 of the last complete calendar year.

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(6) Jointly employ an individual who is employed by the reinsurer unless such RM is under common control with the reinsurer subject to chapter 38, title 41, Idaho Code.

(7) Appoint a sub-RM.

History.

I.C., § 41-5108, as added by 1992, ch. 82, § 1, p. 248.

§ 41-5109. Duties of reinsurers utilizing the services of a reinsurance intermediary — Manager. — (1) A reinsurer shall not engage the services of any person, firm, association or corporation to act as a RM on its behalf unless such person is licensed as required in [section 41-5103\(2\), Idaho Code](#).

(2) The reinsurer shall annually obtain a copy of the statement(s) of the financial condition of each RM which such reinsurer has engaged, prepared by an independent certified accountant in a form acceptable to the director.

(3) If a RM establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the RM. This opinion shall be in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the RM.

(5) Within thirty (30) days of termination of a contract with a RM, the reinsurer shall provide written notification of such termination to the director.

(6) A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder or subproducer of its RM. The provisions of this subsection shall not apply to relationships governed by chapter 38, title 41, Idaho Code, or if applicable, chapter 17, title 41, Idaho Code.

History.

[I.C., § 41-5109](#), as added by 1992, ch. 82, § 1, p. 248; am. 1993, ch. 194, § 35, p. 492.

STATUTORY NOTES

Compiler's Notes.

Section 36 of S.L. 1993, ch. 194 read: “For a period of twenty-four (24) months after the effective date [July 1, 1993] of this act, an insurer may continue to hold any investment which was made prior to the effective date of this act and which, when made, was a lawful investment, and may carry such investment as an admitted asset at a value calculated in accordance with the provisions of the Idaho Insurance Code as in effect immediately prior to the effective date of this act. Thereafter, the investment shall be held and valued in accordance with the Idaho Insurance Code, as then in effect, and to the extent that the investment exceeds any applicable limitations contained in the Idaho Insurance Code, as then in effect, the excess investment shall not be allowed as an admitted asset of the insurer.”

Section 37 of S.L. 1993, ch. 194 read: “The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

§ 41-5110. Examination authority. — (1) A reinsurance intermediary shall be subject to examination by the director. The director shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the director.

(2) A RM may be examined as if it were the reinsurer.

History.

I.C., § 41-5110, as added by 1992, ch. 82, § 1, p. 248.

§ 41-5111. Penalties and liabilities. — (1) A reinsurance intermediary, insurer or reinsurer found by the director, after a hearing conducted in accordance with chapter 52, title 67, Idaho Code, to be in violation of any provision(s) of this chapter shall:

(a) For each separate violation, pay a penalty in an amount not exceeding five thousand dollars (\$5,000);

(b) Be subject to revocation or suspension of its license; and

(c) If a violation was committed by the reinsurance intermediary, such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

(2) The decision, determination or order of the director pursuant to subsection (1) of this section shall be subject to judicial review pursuant to chapter 52, title 67, Idaho Code.

(3) Nothing contained in this section shall affect the right of the director to impose any other penalties provided in the insurance law.

(4) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties or confer any rights to such persons.

History.

I.C., § 41-5111, as added by 1992, ch. 82, § 1, p. 248.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 1992, ch. 82 read: “This act shall be in full force and effect on and after July 1, 1992. No insurer or reinsurer may continue to utilize the services of a reinsurance intermediary on and after October 1, 1992, unless utilization is in compliance with the provisions of this chapter.” Approved March 26, 1992.

Chapter 52

INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT

Sec.

41-5201. Short title.

41-5202. Purpose.

41-5203. Definitions.

41-5204. Applicability and scope.

41-5205. [Reserved.]

41-5206. Restrictions relating to premium rates.

41-5207. Renewability of coverage.

41-5208. Availability of coverage — Preexisting conditions — Portability.

41-5209. Notice of intent to operate as a risk-assuming carrier or a reinsuring carrier.

41-5210. Application to become a risk-assuming carrier.

41-5211. Administrative procedures.

41-5212. Standards to assure fair marketing.

41-5213. Catastrophic plans. [Repealed.]

41-5214. Enhanced short-term plans.

§ 41-5201. Short title. — This chapter shall be known and may be cited as the “Individual Health Insurance Availability Act.”

History.

I.C., § 41-5201, as added by 1994, ch. 427, § 1, p. 1337.

§ 41-5202. Purpose. — The purpose and intent of this chapter is to promote the availability of health insurance coverage to persons not covered by employment based insurance regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, and to improve the overall fairness and efficiency of the individual health insurance market.

This chapter is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

History.

I.C., § 41-5202, as added by 1994, ch. 427, § 1, p. 1337; am. 1997, ch. 321, § 19, p. 948; am. 2000, ch. 472, § 10, p. 1602.

§ 41-5203. Definitions. — As used in this chapter:

(1) “Actuarial certification” means a written statement by a member of the American academy of actuaries or other individual acceptable to the director that an individual carrier is in compliance with the provisions of [section 41-5206, Idaho Code](#), based upon the person’s examination and including a review of the appropriate records and the actuarial assumptions and methods used by the individual carrier in establishing premium rates for applicable health benefit plans.

(2) “Affiliate” or “affiliated” means any entity or person who directly or indirectly through one (1) or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) “Agent” means a producer as defined in [section 41-1003\(8\), Idaho Code](#).

(4) “Base premium rate” means, as to a rating period, the lowest premium rate charged or that could have been charged under a rating system by the individual carrier to individuals with similar case characteristics for health benefit plans with the same or similar coverage.

(5) “Carrier” means any entity that provides health insurance in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a health maintenance organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(6) “Case characteristics” means demographic or other objective characteristics of an individual that are considered by the individual carrier in the determination of premium rates for the individual, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of this chapter.

(7) “Control” shall be defined in the same manner as in [section 41-3802\(2\), Idaho Code](#).

(8) “Dependent” in any new or renewing plan means a spouse, an unmarried child under the age of twenty-five (25) years and who receives more than one-half (½) of his financial support from the parent, or an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

(9) “Director” means the director of the department of insurance of the state of Idaho.

(10) “Eligible individual” means an Idaho resident individual or dependent of an Idaho resident:

(a) Who is under the age of sixty-five (65) years, is not eligible for coverage under a group health plan, part A or part B of title XVIII of the social security act (medicare), or a state plan under title XIX (medicaid) or any successor program, and who does not have other health insurance coverage; or

(b) Who is a federally eligible individual (one who meets the eligibility criteria set forth in the federal health insurance portability and accountability act of 1996, [Public Law 104-191](#), Sec. 2741(b) (HIPAA)).

An “eligible individual” can be the dependent of an eligible employee, which eligible employee is receiving health insurance benefits subject to the regulation of title 41, Idaho Code.

(11) “Enhanced short-term plan” means an individual health benefit plan that:

(a) Has an initial period of less than twelve (12) months and is renewable at the option of the individual for up to the number of months established by rules issued pursuant to [section 41-5214, Idaho Code](#); and

(b) Otherwise meets the standards established by rules issued pursuant to [section 41-5214, Idaho Code](#).

(12) “Established geographic service area” means a geographic area, as approved by the director and based on the carrier’s certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(13) “Health benefit plan” means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional

service corporation, or health maintenance organization subscriber contract and includes enhanced short-term plans. Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(14) "Index rate" means, as to a rating period for individuals with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual basic health benefit plan" means a lower cost health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(16) "Individual carrier" means a carrier that offers health benefit plans covering eligible individuals and their dependents.

(17) "Individual catastrophic A health benefit plan" means a higher limit health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(18) "Individual catastrophic B health benefit plan" means a health benefit plan with limits higher than an individual catastrophic A health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(19) "Individual HSA compatible health benefit plan" means a health savings account compatible health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(20) "Individual standard health benefit plan" means a health benefit plan developed pursuant to chapter 55, title 41, Idaho Code, prior to April 1, 2017.

(21) "New business premium rate" means, as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the individual carrier to individuals with similar case

characteristics for newly issued health benefit plans with the same or similar coverage.

(22) “Premium” means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(23) “Qualifying previous coverage” and “qualifying existing coverage” mean benefits or coverage provided under:

(a) Medicare or medicaid, civilian health and medical program for uniformed services (CHAMPUS), the Indian health service program, a state health benefit risk pool, or any other similar publicly sponsored program; or

(b) Any group or individual health insurance policy or health benefit arrangement whether or not subject to the state insurance laws, including coverage provided by a managed care organization, hospital or professional service corporation, or a fraternal benefit society, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

(24) “Rating period” means the calendar period for which premium rates established by a carrier are assumed to be in effect.

(25) “Reinsuring carrier” means a carrier participating in the Idaho individual high-risk reinsurance pool established in chapter 55, title 41, Idaho Code.

(26) “Restricted network provision” means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

(27) “Risk-assuming carrier” means a carrier whose application is approved by the director pursuant to [section 41-5210, Idaho Code](#).

History.

[I.C., § 41-5203](#), as added by 1994, ch. 427, § 1, p. 1337; am. 1995, ch. 360, § 8, p. 1235; am. 1997, ch. 321, § 20, p. 948; am. 2000, ch. 472, § 11, p. 1602; am. 2001, ch. 296, § 10, p. 1044; am. 2004, ch. 285, § 1, p. 802;

am. 2005, ch. 353, § 1, p. 1111; am. 2007, ch. 148, § 4, p. 427; am. 2009, ch. 125, § 9, p. 391; am. 2013, ch. 266, § 14, p. 652; am. 2017, ch. 281, § 11, p. 733; am. 2019, ch. 301, § 1, p. 893.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 148, in subsection (8), substituted “twenty-one (21) years” for “nineteen (19) years” and “twenty-five (25) years” for “twenty-three (23) years.”

The 2009 amendment, by ch. 125, rewrote subsection (8).

The 2013 amendment, by ch. 266, updated the reference in subsection (7) in light of the 2013 revision of chapter 38, title 41, Idaho Code.

The 2017 amendment, by ch. 281, added “prior to April 1, 2017” at the end of subsections (14), (15), (16), (17) and (18); and substituted “chapter 55, title 41, Idaho Code” for “[section 41-511, Idaho Code](#)” near the end of subsection (17).

The 2019 amendment, by ch. 301, added present subsections (11) and (16) and redesignated the remaining subsections accordingly; added “and includes enhanced short-term plans” at the end of the first sentence in present subsection (13); and deleted former subsection (26), which read: “Individual carrier’ means a carrier that offers health benefit plans covering eligible individuals and their dependents.”

Federal References.

Part A or part B of title XVIII of the Social Security Act (medicare), referred to in subsection (10)(a) of this section, are compiled as [42 U.S.C.S. § 1395c et seq.](#) and [42 U.S.C.S. § 1395j et seq.](#) Title XIX of the Social Security Act (medicaid), also referred to in subsection (10)(a), is compiled as [42 U.S.C.S. § 1396 et seq.](#)

“Eligible individual”, referred to in subsection (10)(b), is defined for the federal health insurance portability and accountability act in [42 U.S.C.S. § 300gg-41\(b\).](#)

For CHAMPUS statutes, referred to in paragraph (21)(a), see **10 USCS § 1071 et seq.**

For Indian health service program, referred to in paragraph (21)(a), see **25 USCS § 1665a.**

Compiler's Notes.

For American academy of actuaries, referred to in subsection (1), see *<https://www.actuary.org>*.

The abbreviations and words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 4 of S.L. 2019, ch. 301 declared an emergency. Approved April 4, 2019.

§ 41-5204. Applicability and scope. — To the extent permitted by federal law, the provisions of this chapter shall apply to any health benefit plan delivered or issued for delivery in the state of Idaho that provides coverage to eligible individuals or their dependents if not otherwise subject to the provisions of chapter 22, 40, 47 or 55, title 41, Idaho Code.

(1) Except as provided in subsection (2) of this section, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one (1) carrier and any restrictions or limitations imposed in this chapter shall apply as if all health benefit plans delivered or issued for delivery to individuals in this state by such affiliated carriers were insured by one (1) carrier.

(2) An affiliated carrier that is a managed care organization having a certificate of authority pursuant to the provisions of chapter 39, title 41, Idaho Code, may be considered to be a separate carrier for the purposes of this chapter.

(3) Unless otherwise authorized by the director, an individual carrier shall not enter into one (1) or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to individuals in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The provisions of sections 41-510, 41-511 and 41-515, Idaho Code, shall apply if an individual carrier cedes or assumes all of the insurance obligation or risk with respect to one (1) or more health benefit plans delivered or issued for delivery to individuals in this state.

History.

I.C., § 41-5204, as added by 1994, ch. 427, § 1, p. 1337; am. 2000, ch. 472, § 12, p. 1602; am. 2017, ch. 76, § 3, p. 197.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 76, substituted “41-515” for “41-514” in the last sentence in subsection (3).

Effective Dates.

Section 13 of S.L. 1994, ch. 427 provided: “Effective Date. The provisions of this act shall be effective July 1, 1994. An individual carrier shall not be required to comply with the provisions of sections 41-5205, 41-5206 and 41-5207, Idaho Code, until January 1, 1995.”

Idaho Code § 41-5205

§ 41-5205. [Reserved.]

Idaho Code § 41-5206

§ 41-5206. Restrictions relating to premium rates. — (1) Premium rates for health benefit plans subject to the provisions of this chapter shall be subject to the following provisions:

(a) The premium rates charged during a rating period to individuals with similar case characteristics for the same or similar coverage, or the rates that could be charged to such individuals under the rating system, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(b) The percentage increase in the premium rate charged to an individual for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the individual carrier is no longer enrolling new individuals, the individual carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the individual carrier is actively enrolling new individuals.

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the individual or dependents as determined from the individual carrier's rate manual; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the individual carrier's rate manual.

(c) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or

payable by carriers pursuant to [section 41-4711, Idaho Code](#), or chapter 55, title 41, Idaho Code.

(d)(i) Individual carriers shall apply rating factors, including case characteristics, consistently with respect to all individuals. Rating factors shall produce premiums for identical individuals which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the individuals assumed to select particular health benefit plans; and

(ii) An individual carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(e) For purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(f) The individual carrier shall not use case characteristics, other than age, individual tobacco use, geography as defined by rule of the director, or gender, without prior approval of the director.

(g) An individual carrier may utilize age as a case characteristic in establishing premium rates, provided that the same rating factor shall be applied to all dependents under twenty-five (25) years of age, and the same rating factor may be applied on an annual basis as to individuals or nondependents twenty (20) years of age or older.

(h) The director may establish rules to implement the provisions of this section and to assure that rating practices used by individual carriers are consistent with the purposes of this chapter, including rules that:

(i) Assure that differences in rates charged for health benefit plans by individual carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the individuals assumed to select particular health benefit plans;

(ii) Prescribe the manner in which case characteristics may be used by individual carriers; and

(iii) Prescribe the manner in which an individual carrier is to demonstrate compliance with the provisions of this section, including requirements that an individual carrier provide the director with actuarial certification as to such compliance.

(2) The director may suspend for a specified period the application of subsection (1)(a) of this section as to the premium rates applicable to one (1) or more individuals for one (1) or more rating periods upon a filing by the individual carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the individual carrier or that the suspension would enhance the efficiency and fairness of the marketplace for individual health insurance.

(3) In connection with the offering for sale of any health benefit plan to an individual, an individual carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for an individual are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the individual and his dependents;

(b) The provisions of the health benefit plan concerning the individual carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(4)(a) Each individual carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each individual carrier shall file with the director annually on or before September 15, an actuarial certification certifying that the carrier is in compliance with the provisions of this chapter and that the rating methods of the individual carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as

specified by the director. A copy of the certification shall be retained by the individual carrier at its principal place of business.

(c) An individual carrier shall make the information and documentation described in subsection (4)(a) of this section available to the director upon request. Except in cases of violations of the provisions of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the department except as agreed to by the individual carrier or as ordered by a court of competent jurisdiction.

History.

I.C., § 41-5206, as added by 1994, ch. 427, § 1, p. 1337; am. 1995, ch. 360, § 9, p. 1235; am. 1997, ch. 232, § 2, p. 675; am. 2000, ch. 415, § 2, p. 1321; am. 2000, ch. 472, § 13, p. 1602; am. 2002, ch. 99, § 2, p. 269; am. 2004, ch. 360, § 2, p. 1076; am. 2007, ch. 148, § 5, p. 427.

STATUTORY NOTES

Amendments.

This section was amended by two 2000 acts which appear to be compatible and have been compiled together.

The 2000 amendment, by ch. 415, § 2, in subsection (1)(h), substituted “under twenty-three (23) years of age” for “under the age of twenty-three (23)”, substituted “may be applied on an annual basis” for “shall be applied on a quinquennial basis”.

The 2000 amendment, by ch. 472, § 13, in the first sentence of subsection (1)(a), substituted “fifty percent (50%)” for “twenty-five percent (25%)”, and added the last sentence; in subsection (1)(c), inserted “Idaho Code, or chapter 55, title 41,” following “section 41-4711,”; deleted former subsection (1)(d) as it appears in the bound volume; redesignated former subsections (1)(e) through (1)(i) as present subsections (1)(d) through (1)(h); in present subsection (1)(g), substituted “under twenty-three (23) years of age” for “under twenty-three (23)”.

The 2007 amendment, by ch. 148, substituted “twenty-five (25) years” for “twenty-three (23) years” in subsection (1)(g).

Effective Dates.

Section 13 of S.L. 1994, ch. 427 provided: “Effective Date. The provisions of this act shall be effective July 1, 1994. An individual carrier shall not be required to comply with the provisions of sections 41-5205, 41-5206 and 41-5207, Idaho Code, until January 1, 1995.”

§ 41-5207. Renewability of coverage. — (1) A health benefit plan subject to the provisions of this chapter shall be renewable with respect to the individual or dependents, at the option of the individual, except in any of the following cases:

- (a) Nonpayment of the required premiums;
- (b) Fraud or intentional misrepresentation of material fact by the individual insured or his representatives. An individual whose coverage is terminated for fraud or misrepresentation shall not be deemed to be an “eligible individual” for a period of twelve (12) months from the effective date of the termination of the individual’s coverage and shall not be deemed to have “qualifying previous coverage” under chapter 22, 47 or 52, title 41, Idaho Code;
- (c) The individual ceases to be an eligible individual as defined in [section 41-5203\(10\), Idaho Code](#);
- (d) In the case of health benefit plans that are made available in the individual market only through one (1) or more associations, as defined in [section 41-2202, Idaho Code](#), the membership of an individual in the association, on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual;
- (e) The individual carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to individuals in this state. Unless otherwise authorized in advance by the department of insurance, a carrier may discontinue a product only after the product has been in use for at least thirty-six (36) consecutive months, provided the carrier may not discontinue more than fifteen percent (15%) of its total number of individuals and dependents in all lines of business regulated by this chapter in a twelve (12) month period. The carrier shall:
 - (i) Provide advance written or electronic notice of its decision under this paragraph to the director;

- (ii) Provide notice of the discontinuation to all affected individuals at least ninety (90) calendar days prior to the date the particular health benefit plan will be discontinued by the carrier, provided that notice to the director under the provisions of this paragraph shall be provided at least fourteen (14) calendar days prior to the notice to the affected individuals;
 - (iii) Offer to each affected individual, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the carrier to individuals in this state;
 - (iv) Act uniformly without regard to any health status-related factor of an affected individual or dependent of an affected individual who may become eligible for the coverage; and
 - (v) Offer the new products at rates that comply with [section 41-5206\(1\)\(b\), Idaho Code](#).
- (f) The individual carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to individuals in this state. In such a case the carrier shall:
- (i) Provide advance notice of its decision under this paragraph to the director; and
 - (ii) Provide notice of the decision not to renew coverage to all affected individuals and to the director at least one hundred eighty (180) calendar days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected individuals;
- (g) The director finds that the continuation of the coverage would:
- (i) Not be in the best interests of the policyholders or certificate holders; or
 - (ii) Impair the carrier's ability to meet its contractual obligations.
- In such instance, the director shall assist affected individuals in finding replacement coverage; or

(h) The plan is an enhanced short-term plan that has reached the limit of renewability established in rules issued by the director and the individual carrier offers the individual the opportunity to reapply for coverage in accordance with the rules issued by the director.

(2) An individual carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(f) of this section shall be prohibited from writing new business in the individual market in this state for a period of five (5) years from the date of notice to the director.

(3) In the case of an individual carrier doing business in one (1) established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

History.

I.C., § 41-5207, as added by 1994, ch. 427, § 1, p. 1337; am. 1995, ch. 360, § 13, p. 1235; am. 1997, ch. 321, § 21, p. 948; am. 1999, ch. 392, § 1, p. 1112; am. 2000, ch. 472, § 14, p. 1602; am. 2006, ch. 353, § 3, p. 1079; am. 2019, ch. 301, § 2, p. 893.

STATUTORY NOTES

Amendments.

The 2006 amendment, by ch. 353, in subsection (1), added (e).

The 2019 amendment, by ch. 301, added paragraph (1)(h); and substituted "section shall apply" for "subsection shall apply" near the end of subsection (3).

Effective Dates.

Section 13 of S.L. 1994, ch. 427 provided: "Effective Date. The provisions of this act shall be effective July 1, 1994. An individual carrier shall not be required to comply with the provisions of sections 41-5205, 41-5206 and 41-5207, Idaho Code, until January 1, 1995."

Section 4 of S.L. 2019, ch. 301 declared an emergency. Approved April 4, 2019.

§ 41-5208. Availability of coverage — Preexisting conditions — Portability. —

(1)(a) Every individual carrier shall, as a condition of offering health benefit plans in this state to individuals, actively offer health benefit plans to individuals, including the individual basic health benefit plan, the individual standard health benefit plan, the individual catastrophic A health benefit plan, the individual catastrophic B health benefit plan and the individual HSA compatible health benefit plan.

(b) An individual carrier shall issue an individual basic, standard, catastrophic A, catastrophic B or HSA compatible health benefit plan to any eligible individual that applies for such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with the provisions of this chapter.

(2)(a) An individual carrier shall file with the director, in a format and manner prescribed by the director, the basic, standard, catastrophic, and HSA compatible health benefit plans to be used by the carrier. A health benefit plan filed pursuant to the provisions of this paragraph may be used by an individual carrier beginning thirty (30) days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the individual carrier, disapprove the continued use by an individual carrier of a basic, standard, catastrophic, or HSA compatible health benefit plan on the grounds that the plan does not meet the requirements of this chapter.

(3) Health benefit plans covering eligible individuals shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

- (i) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;
 - (ii) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or
 - (iii) A pregnancy existing on the effective date of coverage.
- (b) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by qualifying previous coverage, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. As provided in section 2741(b) of the federal health insurance portability and accountability act of 1996 ([42 U.S.C. 300gg-41\(b\)](#)), with regard to federally eligible individuals under HIPAA, any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage shall not apply, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day, and whether or not the condition would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment before that day.
- (c) An individual carrier shall not modify a basic, standard, catastrophic A, catastrophic B or HSA compatible health benefit plan with respect to an individual or any dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.
- (d) In the case of an individual who is eligible for the credit for health insurance costs under [section 35 of the Internal Revenue Code of 1986](#), the preexisting condition limitation shall not apply only if the individual maintained creditable health insurance coverage for an aggregate period of three (3) months as of the date on which the individual seeks to enroll in pool coverage, not counting any period prior to a sixty-three (63) day break in coverage.

(4)(a) An individual carrier shall not be required to offer coverage or accept applications pursuant to the provisions of subsection (1) of this section in the case of the following:

(i) To an individual, where the individual is not residing in the carrier's established geographic service area;

(ii) Within an area where the individual carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to individuals because of its obligations to existing groups or individuals.

(b) An individual carrier that cannot offer coverage pursuant to the provisions of subsection (4)(a)(ii) of this section may not offer coverage in the applicable area to new employer groups with more than fifty (50) eligible employees or to any small employer groups or to any individuals until the later of one hundred eighty (180) days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to individuals and groups.

(5) An individual carrier shall not be required to provide coverage to individuals pursuant to the provisions of subsection (1) of this section for any period of time for which the director determines that requiring the acceptance of individuals in accordance with the provisions of subsection (1) of this section would place the individual carrier in a financially impaired condition.

History.

I.C., § 41-5208, as added by 1994, ch. 427, § 1, p. 1337; am. 1995, ch. 360, § 10, p. 1235; am. 1997, ch. 321, § 22, p. 948; am. 2000, ch. 472, § 15, p. 1602; am. 2004, ch. 285, § 2, p. 802; am. 2004, ch. 332, § 1, p. 988; am. 2005, ch. 353, § 2, p. 1111.

STATUTORY NOTES

Amendments.

This section was amended by two 2004 acts which appear to be compatible and have been compiled together.

The 2004 amendment, by ch. 285, in subsection (3), inserted “eligible” preceding “individuals shall comply”; in subsection (3)(b), deleted “with respect to particular services” preceding “for the period of time”, deleted “to the extent such previous coverage provided benefits with respect to such services” preceding “provided that the qualifying previous coverage”; and added the last sentence.

The 2004 amendment, by ch. 332, added subsection (3)(d).

Federal References.

Section 35 of the Internal Revenue Code of 1986, referred to in subsection (3)(d), is codified as 26 U.S.C.S. § 35.

CASE NOTES

Policy Terms.

Court erred in finding that patient was covered under health insurance policy for surgery on preexisting condition, where that result was not in accordance with the clear language of the policy. *Gravatt v. Regence Blueshield of Idaho*, 136 Idaho 899, 42 P.3d 692 (2002).

§ 41-5209. Notice of intent to operate as a risk-assuming carrier or a reinsuring carrier. —

(1)(a) Each individual carrier shall notify the director within thirty (30) days of the effective date of this chapter of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. An individual carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to the provisions of [section 41-5210, Idaho Code](#).

(b) The decision shall be binding for a five (5) year period except that the initial decision shall be binding for two (2) years. The director may permit a carrier to modify its decision at any time for good cause shown.

(c) The director shall establish an application process for individual carriers seeking to change their status under the provisions of this subsection.

(2) A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

History.

[I.C., § 41-5209](#), as added by 1994, ch. 427, § 1, p. 1337.

STATUTORY NOTES

Compiler's Notes.

The phrase "the effective date of this chapter" in paragraph (1)(a) refers to the effective date of S.L. 1994, Chapter 427, which was effective July 1, 1994.

§ 41-5210. Application to become a risk-assuming carrier. — (1) An individual carrier may apply to become a risk-assuming carrier by filing an application with the director in a form and manner prescribed by the director.

(2) The director shall consider the following factors in evaluating an application filed under the provisions of subsection (1) of this section:

- (a) The carrier's financial condition;
- (b) The carrier's history of rating and underwriting individuals;
- (c) The carrier's commitment to market fairly to all individuals in the state or its established geographic service area, as applicable;
- (d) The carrier's experience with managing the risk of individuals; and
- (e) The extent to which a carrier has and will be able to maintain reinsurance pursuant to the provisions of subsection (3) of [section 41-5204, Idaho Code](#).

(3) The director shall provide public notice of an application by an individual carrier to be a risk-assuming carrier and shall provide at least a sixty (60) day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days of the receipt of the application by the director, the carrier may request a hearing.

(4) The director may rescind the approval granted to a risk-assuming carrier under the provisions of this section if the director finds that:

- (a) The carrier's financial condition will no longer support the assumption of risk from issuing coverage to individuals in compliance with the provisions of [section 41-5208, Idaho Code](#), without the protection afforded by the program;
- (b) The carrier has failed to market fairly to all individuals in the state or its established geographic service area, as applicable; or
- (c) The carrier has failed to provide coverage to eligible individuals as required in [section 41-5208, Idaho Code](#).

(5) An individual carrier electing to be a risk-assuming carrier shall not be subject to the provisions of [section 41-4711, Idaho Code](#), except to the extent such individual carrier is subject to assessment for additional funding pursuant to the provisions of subsection (12)(c) of [section 41-4711, Idaho Code](#).

History.

[I.C., § 41-5210](#), as added by 1994, ch. 427, § 1, p. 1337.

§ 41-5211. Administrative procedures. — The director shall promulgate rules in accordance with the provisions of chapter 52, title 67, Idaho Code, for the implementation and administration of the individual health coverage reform act [individual health insurance availability act].

History.

I.C., § 41-5211, as added by 1994, ch. 427, § 1, p. 1337.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion at the end of the section was added by the compiler as the probable intended reference. See § 41-5201 et seq.

§ 41-5212. Standards to assure fair marketing. — (1) Each individual carrier shall actively market health benefit plan coverage, including the individual basic, standard, catastrophic A, catastrophic B, and HSA compatible health benefit plans, to eligible individuals in the state. If an individual carrier denies coverage to an individual on the basis of the health status or claims experience of the individual or dependents, the individual carrier shall offer the individual the opportunity to purchase an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan.

(2)(a) Except as provided in subsection (2)(b) of this section, no individual carrier or agent shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing individuals to refrain from filing an application for coverage with the individual carrier because of the health status, claims experience, industry, occupation or geographic location of the individual or dependents.

(ii) Encouraging or directing individuals to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the individual.

(b) The provisions of subsection (2)(a) of this section shall not apply with respect to information provided by an individual carrier or agent to an individual regarding the established geographic service area or a restricted network provision of an individual carrier.

(3)(a) Except as provided in subsection (2)(b) of this section, no individual carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be carried because of the health status, claims experience, industry, occupation or geographic location of the individual.

(b) The provisions of paragraph (a) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the

percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the individual.

(4) An individual carrier shall provide reasonable compensation, as provided under the plan of operation of the individual high risk reinsurance pool, to an agent, if any, for the sale of an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan.

(5) No individual carrier may terminate, fail to renew or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation or geographic location of the individuals placed by the agent with the individual carrier.

(6) Denial by an individual carrier of an application for coverage from an individual shall be in writing and shall state the reason or reasons for the denial.

(7) The director may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to individuals in this state.

(8)(a) A violation of the provisions of this section by an individual carrier or an agent shall be an unfair trade practice pursuant to the provisions of [section 41-1302, Idaho Code](#).

(b) If an individual carrier enters into a contract, agreement or other arrangement with a third party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to individuals in this state, the third party administrator shall be subject to the provisions of this section as if it were an individual carrier.

History.

[I.C., § 41-5212](#), as added by 1994, ch. 427, § 1, p. 1337; am. 1995, ch. 360, § 11, p. 1235; am. 1997, ch. 321, § 23, p. 948; am. 2000, ch. 472, § 16, p. 1602; am. 2005, ch. 353, § 3, p. 1111.

STATUTORY NOTES

Effective Dates.

Section 13 of S.L. 1994, ch. 427 provided: “Effective Date. The provisions of this act shall be effective July 1, 1994. An individual carrier shall not be required to comply with the provisions of sections 41-5205, 41-5206 and 41-5207, Idaho Code, until January 1, 1995.”

§ 41-5213. Catastrophic plans. [Repealed.]

STATUTORY NOTES

Compiler's Notes.

This section, which comprised I.C., § 41-5213, as added by 1995, ch. 360, § 15, p. 1235, was repealed by S.L. 2000, ch. 472, § 9, effective July 1, 2000.

§ 41-5214. Enhanced short-term plans. — The director shall adopt reasonable rules to establish specific standards for enhanced short-term plans. The standards shall be in addition to and in accordance with applicable laws of this state, including this chapter. The standards:

(1) Shall include requirements for renewability that are consistent with federal law regarding short-term, limited duration insurance; and (2) May include, but need not be limited to: (a) A scope of covered benefits, which may be as broad as the scope of covered benefits required to be included in individual health benefit plans that are not deemed short-term, limited duration insurance under federal law; (b) Restrictions on premium rate increases when an enhanced short-term plan ceases to be renewable and the individual policyholder reapplies for coverage from the same carrier; and (c) Conversion of enhanced short-term plans into fully renewable coverage upon a finding by the director that the conversion complies with law and is in the best interests of the public.

History.

I.C., § 41-5214, as added by 2019, ch. 301, § 3, p. 893.

STATUTORY NOTES

Effective Dates.

Section 4 of S.L. 2019 ch. 301 declared an emergency. Approved April 4, 2019.

Chapter 53
MEDICAL CARE SAVINGS ACCOUNT ACT

Sec.

41-5301 — 41-5306. [Repealed.]

**§ 41-5301 — 41-5306. Medical Care Savings Account Act.
[Repealed.]**

STATUTORY NOTES

Compiler's Notes.

The following sections were repealed by S.L. 1995, ch. 362, § 1, effective January 1, 1995: § 41-5301, which comprised I.C., § 41-5301, as added by 1994, ch. 186, § 2, p. 606.

§ 41-5302, which comprised I.C., § 41-5302, as added by 1994, ch. 186, § 2, p. 606.

§ 41-5303, which comprised I.C., § 41-5303, as added by 1994, ch. 186, § 2, p. 606.

§ 41-5304, which comprised I.C., § 41-5304, as added by 1994, ch. 186, § 2, p. 606.

§ 41-5305, which comprised I.C., § 41-5305, as added by 1994, ch. 186, § 2, p. 606.

§ 41-5306, which comprised I.C., § 41-5306, as added by 1994, ch. 186, § 2, p. 606.

Chapter 54

RISK-BASED CAPITAL (RBC) FOR INSURERS ACT

Sec.

41-5401. Definitions.

41-5402. RBC Reports.

41-5403. Company action level event.

41-5404. Regulatory action level event.

41-5405. Authorized control level event.

41-5406. Mandatory control level event.

41-5407. Hearings.

41-5408. Confidentiality — Prohibition on announcements, prohibition on use in ratemaking.

41-5409. Supplemental provisions — Rules — Exemption.

41-5410. Foreign insurers.

41-5411. Immunity.

41-5412. Notices.

41-5413. Severability.

§ 41-5401. Definitions. — As used in this chapter, these terms shall have the following meanings:

(1) “Adjusted RBC report” means an RBC report which has been adjusted by the director in accordance with [section 41-5402\(5\), Idaho Code](#).

(2) “Corrective order” means an order issued by the director specifying corrective actions which the director has determined are required.

(3) “Domestic insurer” means any insurer domiciled in this state.

(4) “Foreign insurer” means any insurer not domiciled in this state.

(5) “Health organization” means any hospital service corporation or professional service corporation licensed under chapter 34, title 41, Idaho Code.

(6) “Insurer” means any insurance company authorized to transact insurance business in this state and includes a fraternal benefit society and a health organization unless the context otherwise requires.

(7) “Life and/or health insurer” means any insurer licensed under chapter 3, title 41, Idaho Code, to transact life, disability, accident and/or health insurance and includes any managed care organization within the scope of [section 41-3921\(1\), Idaho Code](#), or a licensed property and casualty insurer writing only disability or accident and health insurance.

(8) “NAIC” means the national association of insurance commissioners.

(9) “Negative trend” means, with respect to a life and/or health insurer or a fraternal benefit society, a negative trend over a period of time, as determined in accordance with the “Trend Test Calculation” included in the life or fraternal RBC instructions.

(10) “Property and casualty insurer” means any insurer licensed under chapter 3, title 41, Idaho Code, to transact property and casualty insurance, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers, title insurers, farm and county mutuals and domestic reciprocal insurers with fewer than seven (7) subscribers which insure only

worker's compensation risk in this state and which only issue fully assessable policies.

(11) "RBC" means risk-based capital.

(12) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(13) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC;

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(14) "RBC plan" means a comprehensive financial plan containing the elements specified in [section 41-5403\(2\), Idaho Code](#). If the director rejects the RBC plan and it is revised by the insurer, with or without the director's recommendation, the plan shall be called the "revised RBC plan."

(15) "RBC report" means the report required in [section 41-5402, Idaho Code](#).

(16) "Total adjusted capital" means the sum of:

(a) An insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under section 41-335, 41-3225 or 41-3425, Idaho Code; and

(b) Such other items, if any, as the RBC instructions may provide.

History.

I.C., § 41-5401, as added by 1996, ch. 96, § 1, p. 282; am. 2004, ch. 255, § 1, p. 726; am. 2014, ch. 319, § 1, p. 785.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, rewrote the section, adding present subsections (5) and (6) and redesignating the subsequent subsections.

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (8), see *<http://naic.org>*.

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-5402. RBC Reports. — (1) Every domestic insurer shall, on or prior to each March 1 (the “filing date”), prepare and submit to the director a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and (b) With the insurance director in any state in which the insurer is authorized to do business, if the insurance director has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of: (i) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or (ii) The filing date.

(2) A life and health insurer’s or fraternal benefit society’s RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account, and may adjust for the covariance between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions: (a) The risk with respect to the insurer’s assets; (b) The risk of adverse insurance experience with respect to the insurer’s liabilities and obligations; (c) The interest rate risk with respect to the insurer’s business; and (d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(3) A property and casualty insurer’s or health organization’s RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account, and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions: (a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and (d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules and instructions referenced in this chapter is desirable in the business of

insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this chapter. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this chapter.

(5) If a domestic insurer files an RBC report which in the judgment of the director is inaccurate, then the director shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an “adjusted RBC report.”

History.

I.C., § 41-5402, as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 2, p. 785.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, inserted “or fraternal benefit society’s” in the first sentence of the introductory language in subsection (2) and inserted “or health organization’s” in the first sentence of the introductory language in subsection (3).

Compiler’s Notes.

As to national association of insurance commissioners (NAIC), referred to in paragraph (1)(a), see <http://naic.org>.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-5403. Company action level event. — (1) “Company action level event” means any of the following events:

(a) The filing of an RBC report by an insurer which indicates that:

(i) The insurer’s total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) If a life and/or health insurer that completes the life annual statement for the reporting year or fraternal benefit society, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and has a negative trend; or

(iii) If a property or casualty insurer, health organization or health insurer that completes the health annual statement for the reporting year, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty or health RBC instructions;

(b) The notification by the director to the insurer of an adjusted RBC report that indicates an event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under [section 41-5407, Idaho Code](#); or

(c) If, pursuant to [section 41-5407, Idaho Code](#), an insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the director to the insurer that the director has, after a hearing, rejected the insurer’s challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the director an RBC plan which shall:

(a) Identify the conditions which contribute to the company action level event;

(b) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, and for managed care organizations and health organizations for at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the insurer's business, including but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five (45) days of the company action level event; or

(b) If the insurer challenges an adjusted RBC report pursuant to [section 41-5407, Idaho Code](#), within forty-five (45) days after notification to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(4) Within sixty (60) days after the submission by an insurer of an RBC plan to the director, the director shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the director, unsatisfactory. If the director determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the director. Upon notification from the director, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the director, and shall submit the revised RBC plan to the director:

- (a) Within forty-five (45) days after the notification from the director; or
- (b) If the insurer challenges the notification from the director under [section 41-5407, Idaho Code](#), within forty-five (45) days after a notification to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the director to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the director may, at the director's discretion, subject to the insurer's right to a hearing under [section 41-5407, Idaho Code](#), specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer that files an RBC plan or revised RBC plan with the director shall file a copy of the RBC plan or revised RBC plan with the insurance director in any state in which the insurer is authorized to do business if:

- (a) Such state has an RBC provision substantially similar to [section 41-5408\(1\), Idaho Code](#); and
- (b) The insurance director of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:
 - (i) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or
 - (ii) The date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4) of this section.

History.

[I.C., § 41-5403](#), as added by 1996, ch. 96, § 1, p. 282; am. 2007, ch. 277, § 1, p. 80; am. 2014, ch. 319, § 3, p. 785.

STATUTORY NOTES

Amendments.

The 2007 amendment, by ch. 277, added subsection (1)(a)(iii).

The 2014 amendment, by ch. 319, in subsection (1), in paragraph (a)(ii), inserted “that completes the life annual statement for the reporting year or fraternal benefit society” and “3.0” for “2.5”, and, in paragraph (a)(iii) inserted “health organization or health insurer that completes the health annual statement for the reporting year” near the beginning and “or health” following “casualty”; and inserted “and for managed care organizations and health organizations for at least the two (2) succeeding years” in the first sentence of paragraph (2)(c).

Compiler’s Notes.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-5404. Regulatory action level event. — (1) “Regulatory action level event” means, with respect to any insurer, any of the following events:

- (a) The filing of an RBC report by the insurer which indicates that the insurer’s total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;
- (b) The notification by the director to an insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under [section 41-5407, Idaho Code](#);
- (c) If, pursuant to [section 41-5407, Idaho Code](#), the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the director to the insurer that the director has, after a hearing, rejected the insurer’s challenge;
- (d) The failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the director and has cured the failure within ten (10) days after the filing date;
- (e) The failure of the insurer to submit an RBC plan to the director within the time period set forth in [section 41-5403\(3\), Idaho Code](#);
- (f) Notification by the director to the insurer that:
 - (i) The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the director, unsatisfactory; and
 - (ii) Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under [section 41-5407, Idaho Code](#);
- (g) If, pursuant to [section 41-5407, Idaho Code](#), the insurer challenges a determination by the director under paragraph (f) of this subsection, the notification by the director to the insurer that the director has, after a hearing, rejected such challenge;

(h) Notification by the director to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the director has so stated in the notification, provided the insurer has not challenged the determination under [section 41-5407, Idaho Code](#); or

(i) If, pursuant to [section 41-5407, Idaho Code](#), the insurer challenges a determination by the director under paragraph (h) of this subsection, the notification by the director to the insurer that the director has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event the director shall:

(a) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis as the director deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the director shall determine are required (a “corrective order”).

(3) In determining corrective actions, the director may take into account such factors as are deemed relevant with respect to the insurer based upon the director’s examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five (45) days after the occurrence of the regulatory action level event;

(b) If the insurer challenges an adjusted RBC report pursuant to [section 41-5407, Idaho Code](#), and the challenge is not frivolous in the judgment of the director, within forty-five (45) days after the notification to the insurer that the director has, after a hearing, rejected the insurer’s challenge; or

(c) If the insurer challenges a revised RBC plan pursuant to [section 41-5407, Idaho Code](#), and the challenge is not frivolous in the judgment of the director, within forty-five (45) days after the notification to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(4) The director may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the director to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the director.

History.

[I.C., § 41-5404](#), as added by 1996, ch. 96, § 1, p. 282.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-5405. Authorized control level event. — (1) “Authorized control level event” means any of the following events:

(a) The filing of an RBC report by the insurer which indicates that the insurer’s total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) The notification by the director to the insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under [section 41-5407, Idaho Code](#);

(c) If, pursuant to [section 41-5407, Idaho Code](#), the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the director to the insurer that the director has, after a hearing, rejected the insurer’s challenge;

(d) The failure of the insurer to respond, in a manner satisfactory to the director, to a corrective order, provided the insurer has not challenged the corrective order under [section 41-5407, Idaho Code](#); or

(e) If the insurer has challenged a corrective order under [section 41-5407, Idaho Code](#), and the director has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the director, to the corrective order subsequent to rejection or modification by the director.

(2) In the event of an authorized control level event with respect to an insurer, the director shall:

(a) Take such actions as are required under [section 41-5404, Idaho Code](#), regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) If the director deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control pursuant to chapter 33, title 41, Idaho Code. In the event the director takes such actions, the authorized control level event shall be deemed

sufficient grounds for the director to take action pursuant to chapter 33, title 41, Idaho Code, and the director shall have the rights, powers and duties with respect to the insurer as are set forth in chapter 33, title 41, Idaho Code. In the event the director takes actions under this paragraph pursuant to an adjusted RBC report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of [section 41-3309, Idaho Code](#), pertaining to summary proceedings.

History.

[I.C., § 41-5405](#), as added by 1996, ch. 96, § 1, p. 282.

§ 41-5406. Mandatory control level event. — (1) “Mandatory control level event” means any of the following events:

- (a) The filing of an RBC report that indicates that the insurer’s total adjusted capital is less than its mandatory control level RBC;
- (b) Notification by the director to the insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under [section 41-5407, Idaho Code](#); or
- (c) If, pursuant to [section 41-5407, Idaho Code](#), the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the director to the insurer that the director has, after a hearing, rejected the insurer’s challenge.

(2) In the event of a mandatory control level event:

- (a) With respect to a life and/or health insurer that completes the life annual statement for the reporting year or fraternal benefit society, the director shall take such actions as are necessary to place the insurer under regulatory control pursuant to chapter 33, title 41, Idaho Code. In that event, the mandatory control level event shall be deemed sufficient grounds for the director to take action pursuant to chapter 33, title 41, Idaho Code, and the director shall have the rights, powers and duties with respect to the insurer as are set forth in chapter 33, title 41, Idaho Code. If the director takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of [section 41-3309, Idaho Code](#), pertaining to summary proceedings. Notwithstanding any of the foregoing, the director may forgo action for up to ninety (90) days after the mandatory control level event if the director finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.
- (b) With respect to a property and casualty insurer, health organization or health insurer that completes the health annual statement for the reporting year, the director shall take such actions as are necessary to place the insurer under regulatory control pursuant to chapter 33, title 41, Idaho

Code, or, in the case of an insurer which is writing no business and which is running off its existing business, may allow the insurer to continue its run off under the supervision of the director. In either event, the mandatory control level event shall be deemed sufficient grounds for the director to take action pursuant to chapter 33, title 41, Idaho Code, and the director shall have the rights, powers and duties with respect to the insurer as are set forth in chapter 33, title 41, Idaho Code. If the director takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of [section 41-3309, Idaho Code](#), pertaining to summary proceedings. Notwithstanding any of the foregoing, the director may forgo action for up to ninety (90) days after the mandatory control level event if the director finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

History.

[I.C., § 41-5406](#), as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 4, p. 785.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, substituted “and/or health insurer that completes the life annual statement for the reporting year or fraternal benefit society” for “insurer” near the beginning of paragraph (2)(a) and inserted “health organization or health insurer that completes the health annual statement for the reporting year” near the beginning of paragraph (2)(b).

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-5407. Hearings. — Upon any of the following the insurer shall have the right to a confidential departmental hearing, on a record, at which the insurer may challenge any determination or action by the director. The insurer shall notify the director of its request for a hearing within five (5) days after the notification by the director under subsection (1), (2), (3) or (4) of this section. Upon receipt of the insurer's request for a hearing, the director shall set a date for the hearing, which date shall be no less than ten (10) nor more than thirty (30) days after the date of the insurer's request.

(1) Notification to an insurer by the director of an adjusted RBC report; or (2) Notification to an insurer by the director that: (a) The insurer's RBC plan or revised RBC plan is unsatisfactory; and (b) Such notification constitutes a regulatory action level event with respect to such insurer; or (3) Notification to any insurer by the director that the insurer has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or (4) Notification to an insurer by the director of a corrective order with respect to the insurer.

History.

I.C., § 41-5407, as added by 1996, ch. 96, § 1, p. 282.

§ 41-5408. Confidentiality — Prohibition on announcements, prohibition on use in ratemaking. — (1) All RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the director pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer which are filed with the director, constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the director and shall be considered privileged. Notwithstanding the provisions of chapter 1, title 74, Idaho Code, this information shall not be made public or be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties.

(2) Neither the director nor any person who received documents, materials or other information while acting under the authority of the director shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information obtained or provided pursuant to subsection (1) of this section.

(3) In order to assist in the performance of his duties under this chapter, the director may:

(a) Share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other states, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(b) Receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the

NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material or information received with notice of or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) Enter into agreements governing the sharing and use of information consistent with the provisions of this subsection.

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information referenced in this section shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in subsection (3) of this section.

(5) It is the judgment of the legislature that the comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this chapter, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the insurers' RBC levels is published in any written publication and the insurer is able to demonstrate to the director with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(6) It is the further judgment of the legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the director in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the director for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the director to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

History.

[I.C., § 41-5408](#), as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 5, p. 785; am. 2015, ch. 141, § 116, p. 379.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, in subsection (1), inserted “and shall be considered privileged” at the end of the first sentence, rewrote the second sentence, and added the last sentence; inserted present subsections (2) through (4), and redesignated the subsequent subsections accordingly.

The 2015 amendment, by ch. 141, substituted “chapter 1, title 74” for “chapter 3, title 9” in the second sentence of subsection (1).

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-5409. Supplemental provisions — Rules — Exemption. — (1)

The provisions of this chapter are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the director under such laws, including, but not limited to, chapter 33, title 41, Idaho Code, and rules adopted by the department of insurance relating to the director's authority for companies deemed to be in hazardous financial condition.

(2) The director may adopt reasonable rules necessary for the implementation of this chapter in accordance with the provisions of chapter 52, title 67, Idaho Code.

(3) Upon written application, the director may exempt from compliance with this chapter, for a specified period or periods, any domestic property and casualty insurer, domestic managed care organization or domestic health organization which:

- (a) Writes direct business only in this state; and
- (b) Writes direct annual premiums of two million dollars (\$2,000,000) or less; and
- (c) Assumes no reinsurance in excess of five percent (5%) of direct premium written; or
- (d) Is a managed care organization offering only a limited managed care plan, a hospital service corporation or a professional service corporation that covers less than two thousand (2,000) lives.

History.

I.C., § 41-5409, as added by 1996, ch. 96, § 1, p. 282; am. 2014, ch. 319, § 6, p. 785.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 319, in subsection (3), inserted “domestic managed care organization or domestic health organization” in the

introductory language and added paragraph (d).

Effective Dates.

Section 9 of S.L. 2014, ch. 319 provided that the act should take effect on and after January 1, 2015.

§ 41-5410. Foreign insurers. — (1) Any foreign insurer shall, upon the written request of the director, submit to the director an RBC report as of the end of the calendar year just ended the later of:

(a) The date an RBC report would be required to be filed by a domestic insurer under this chapter; or (b) Fifteen (15) days after the request is received by the foreign insurer.

Any foreign insurer shall, at the written request of the director, promptly submit to the director a copy of any RBC plan that is filed with the insurance director of any other state.

(2) In the event of a company action level event, regulatory action level event or authorized control level event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer (or, if no RBC statute is in force in that state, under the provisions of this chapter), if the insurance director of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute (or, if no RBC statute is in force in that state, under [section 41-5403, Idaho Code](#)), the director may require the foreign insurer to file an RBC plan with the director. In such event, the failure of the foreign insurer to file an RBC plan with the director shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the director may make application to the district court for Ada county, state of Idaho, as permitted under chapter 33, title 41, Idaho Code, with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

History.

[I.C., § 41-5410](#), as added by 1996, ch. 96, § 1, p. 282.

STATUTORY NOTES

Compiler's Notes.

The words enclosed in parentheses so appeared in the law as enacted.

§ 41-5411. Immunity. — There shall be no liability on the part of, and no cause of action shall arise against, the director or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

History.

I.C., § 41-5411, as added by 1996, ch. 96, § 1, p. 282.

§ 41-5412. Notices. — All notices by the director to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

History.

I.C., § 41-5412, as added by 1996, ch. 96, § 1, p. 282.

§ 41-5413. Severability. — The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

History.

I.C., § 41-5413, as added by 1996, ch. 96, § 1, p. 282.

STATUTORY NOTES

Compiler's Notes.

The words “this act” refer to S.L. 1996, Chapter 96, which is compiled as §§ 41-5401 to 41-5413.

Chapter 55

IDAHO INDIVIDUAL HIGH RISK REINSURANCE POOL

Sec.

41-5501. Definitions.

41-5502. Creation of the individual high risk reinsurance pool — Board.

41-5503. Plan of operation.

41-5504. Powers and authority.

41-5505. Reinsurance.

41-5506. Reinsurance premium rates.

41-5507. Premium rates for high risk pool plan coverage.

41-5508. Assessments.

41-5509. Ceding eligibility.

41-5510. [Amended and Redesignated.]

41-5511. Design of products. [Repealed.]

§ 41-5501. Definitions. — As used in this chapter:

(1) “Agent” means a producer as defined in [section 41-1003\(8\), Idaho Code](#).

(2) “Board” means the board of directors of the Idaho individual high risk reinsurance pool established in this chapter and the Idaho small employer health reinsurance program established in [section 41-4711, Idaho Code](#).

(3) “Carrier” means any entity that provides, or is authorized to provide, health insurance in this state. For purposes of this chapter, carrier includes an insurance company, any other entity providing reinsurance including excess or stop loss coverage, a hospital or professional service corporation, a fraternal benefit society, a managed care organization, any entity providing health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) “Dependent” means a spouse, a child or any other individual listed as having coverage under the primary policy holder’s or subscriber’s health benefit plan.

(5) “Director” means the director of the department of insurance of the state of Idaho.

(6) “Eligible individual” means an Idaho resident individual or dependent of an Idaho resident who is:

(a) Not eligible for coverage under a group health benefit plan, part A or part B of title XVIII of the social security act (medicare), or a state plan under title XIX (medicaid) or any successor program, and who does not have other health insurance coverage; and

(b) Enrolled in an individual health benefit plan.

(7) “Health benefit plan” means any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or health maintenance organization subscriber contract.

Health benefit plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(8) "High risk medical condition" means a medical condition or diagnosis identified by the board in its plan of operation as making an individual eligible for reinsurance through the pool.

(9) "High risk pool plan" means an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan issued pursuant to this chapter prior to April 1, 2017.

(10) "High risk pool plan premium" means all moneys paid by an individual or a dependent as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

(11) "Individual carrier" means a carrier that offers individual health benefit plans.

(12) "Plan of operation" means the plan of operation of the individual high risk reinsurance pool established pursuant to this chapter.

(13) "Pool" means the Idaho [individual] high risk reinsurance pool.

(14) "Reinsurance premium" means the premium set by the board pursuant to [section 41-5506, Idaho Code](#), to be paid by a reinsuring carrier for eligible individuals ceded to the pool.

(15) "Reinsuring carrier" means a carrier participating in the individual high risk reinsurance pool established by this chapter.

History.

[I.C., § 41-5501](#), as added by 2000, ch. 472, § 17, p. 1602; am. 2001, ch. 296, § 11, p. 1044; am. 2003, ch. 267, § 3, p. 706; am. 2004, ch. 285, § 3, p. 802; am. 2004, ch. 332, § 2, p. 988; am. 2005, ch. 25, § 96, p. 82; am. 2005, ch. 353, § 4, p. 1111; am. 2007, ch. 148, § 6, p. 427; am. 2008, ch. 297, § 1, p. 831; am. 2009, ch. 125, § 10, p. 391; am. 2017, ch. 281, § 1, p. 733.

STATUTORY NOTES

Amendments.

This section was amended by two 2004 acts which have been compiled together.

The 2004 amendment, by ch. 285, added a subsection (6)(b) which was redesignated as (6)[(c)] because of the conflicting amendment by S.L. 2004, ch. 332 and, in subsection (17)(b) deleted “, hospital or professional service corporation,” preceding “or a fraternal benefit society” and deleted “, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan” from the end.

The 2004 amendment, by ch. 332, added subsection (6)(b).

This section was amended by two 2005 acts which appear to be compatible and have been compiled together.

The 2005 amendment, by ch. 25, corrected an internal designation in subsection (6).

The 2005 amendment, by ch. 353, made the same correction as ch. 25, added present subsection (12), and inserted “or HSA compatible” in the last paragraph of subsection (6) and in present subsection (14).

The 2007 amendment, by ch. 148, in subsection (4), substituted “twenty-one (21) years” for “nineteen (19) years” and “twenty-five (25) years” for “twenty-three (23) years.”

The 2008 amendment, by ch. 297, added the exception in the last paragraph in subsection (6).

The 2009 amendment, by ch. 125, rewrote subsection (4).

The 2017 amendment, by ch. 281, rewrote the section to the extent that a detailed comparison is impracticable.

Federal References.

Part A or part B of title XVIII of the Social Security Act (medicare), referred to in subsection (6)(a) of this section, are compiled as [42 U.S.C.S. § 1395c et seq.](#) and [42 U.S.C.S. § 1395j et seq.](#)

Title XIX of the Social Security Act (medicaid), referred to in subsection (6)(a), is compiled as [42 U.S.C.S. § 1396 et seq.](#)

Compiler's Notes.

The bracketed insertion in subsection (13) was added by the compiler to correct the name of the referenced pool. See § 41-5502.

The words enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 5 of S.L. 2003, ch. 267 declared an emergency. Approved April 8, 2003.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer. [87 A.L.R.6th 319.](#)

§ 41-5502. Creation of the individual high risk reinsurance pool — Board. — (1) There is hereby created an independent public body corporate and politic to be known as the Idaho individual high risk reinsurance pool. The pool will perform an essential governmental function in the exercise of powers conferred upon it in this chapter. The pool and any assessments imposed or collected pursuant to the operation of the pool shall at all times be free from taxation of every kind.

(2) The pool created by this chapter and the small employer [health] reinsurance program established in [section 41-4711, Idaho Code](#), shall operate subject to the supervision and control of the board. The board shall consist of ten (10) members. Eight (8) members shall be appointed by the director and serve at the pleasure of the director. The director or his designated representative shall serve as an ex officio member of the board. In selecting the members of the board the director shall appoint four (4) members representing carriers, two (2) disability agents and two (2) members representing consumer interests. One (1) member shall be a member of the senate appointed by the president pro tempore of the senate and one (1) member shall be a member of the house of representatives appointed by the speaker of the house.

(3) The initial nonlegislative board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent nonlegislative board members shall serve for a term of three (3) years. Legislative members of the board shall serve for a term of two (2) years. A vacancy in a legislative member's position on the board shall be filled in the same manner as the original appointment. All other vacancies on the board shall be filled by the director. A nonlegislative board member may be removed by the director for cause.

History.

[I.C., § 41-5502](#), as added by 2000, ch. 472, § 17, p. 1602.

STATUTORY NOTES

Compiler's Notes.

The bracketed insertion in the first sentence in subsection (2) was added by the compiler to correct the name of the referenced program.

§ 41-5503. Plan of operation. — (1) The board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the pool, and to provide for the sharing of pool gains or losses on an equitable and proportionate basis in accordance with the provisions of this chapter. The plan of operation shall become effective upon written approval by the director.

(2) If the board fails to submit a suitable plan of operation, the director shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The director shall approve the plan of operation submitted by the board, or adopt a temporary plan of operation if the board fails to submit a suitable plan. The director shall amend or rescind any plan adopted under the provisions of this section at the time a plan of operation is submitted by the board and approved by the director.

(3) The plan of operation shall:

(a) Establish procedures for handling and accounting of pool assets and moneys and for an annual fiscal reporting to the director; (b) Establish procedures for selecting an administrator, and setting forth the powers and duties of the administrator; (c) Establish procedures for reinsuring risks in accordance with the provisions of this chapter; (d) Establish procedures and conditions for a carrier to cede individuals with certain high risk medical conditions; (e) Define the high risk medical conditions for which carriers are allowed to cede for reinsurance; (f) Set forth the reinsurance parameters including, but not limited to, the initial level of claims for which the reinsuring carrier is responsible, the coinsurance percentage at which claims above the initial level are reinsured by the pool, and the maximum claims limit above which the pool no longer reimburses; (g) Establish procedures for collecting assessments from carriers to fund claims and administrative expenses incurred or estimated

to be incurred by the pool; and (h) Provide for any additional matters necessary for the implementation and administration of the pool.

History.

I.C., § 41-5503, as added by 2000, ch. 472, § 17, p. 1602; am. 2017, ch. 281, § 2, p. 733.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 281, in subsection (3), added present paragraphs (d) to (f), redesignating former paragraphs (d) and (e) as present paragraphs (g) and (h).

§ 41-5504. Powers and authority. — (1) The pool shall have the general powers and authority granted under the laws of this state to insurance companies and managed care organizations licensed to transact business, except the power to issue health benefit plans directly to individuals. In addition thereto, the pool shall have the specific authority to:

- (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the director, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;
- (b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the pool or any carrier;
- (c) Define the high risk medical conditions for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this chapter;
- (d) Establish rules, conditions and procedures for reinsuring risks under the pool;
- (e) Establish actuarial functions as appropriate for the operation of the pool;
- (f) Assess carriers in accordance with the provisions of [section 41-5508, Idaho Code](#), and make advance interim assessments of carriers as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;
- (g) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(h) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for carriers and may be carried as admitted assets;

(i) Establish rules, policies and procedures as may be necessary or convenient for the implementation of this chapter and the operation of the pool.

(2) Neither the board nor its employees shall be liable for any obligations of the pool. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. The board may provide for indemnification of, and legal representation for, its members and employees.

(3) No participation of a reinsuring carrier in the pool, no establishment of rates, forms or procedures, and no other joint or collective action required under the provisions of this chapter shall be grounds for any legal action, criminal or civil liability, or penalty against the pool or any of its reinsuring carriers either jointly or separately.

History.

I.C., § 41-5504, as added by 2000, ch. 472, § 17, p. 1602; am. 2017, ch. 281, § 3, p. 733.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 281, in subsection (1), substituted “high risk medical conditions” for “health benefit plans, which plans shall allow coordination of benefits” near the beginning of paragraph (c).

§ 41-5505. Reinsurance. — (1) Any individual carrier issuing a health benefit plan shall be liable to the pool for the reinsurance premium and shall be reinsured by the pool for each eligible individual ceded in accordance with [section 41-5509, Idaho Code](#), and the plan of operation.

(2) The pool shall reimburse a reinsuring carrier with respect to the claims of a ceded eligible individual incurred during the calendar year and paid by the reinsuring carrier for benefits covered by the health benefit plan, in accordance with the reinsurance parameters set forth in the plan of operation.

(a) The board may annually adjust the reinsurance parameters by submitting an amendment to the plan of operation in accordance with [section 41-5503\(1\), Idaho Code](#). The adjustments may reflect increases in costs and utilization within the individual market for health benefit plans but must consider the availability of pool funding and the stability of the individual health insurance market, as well as any objectives stated in the plan of operation.

(b) The board shall not submit for approval by the director a plan of operation or an amendment thereto with an initial level of less than twenty-five thousand dollars (\$25,000) or a reinsuring carrier coinsurance percentage of less than twenty percent (20%).

(3) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(4) Each carrier shall make a filing with the director containing the carrier's earned health insurance premium derived from health benefit plans delivered or issued for delivery in this state in the previous calendar year.

(5) Each carrier shall file with the director, in a form and manner to be prescribed by the director, an annual report. The report shall state the number of resident persons insured under the carrier's health benefit plan, or through excess or stop loss coverage.

(6) Carriers shall permit individuals and their dependents covered by a high risk pool plan to remain on the high risk pool plan as long as the individual continues to meet the conditions of [section 41-5501\(6\)\(a\), Idaho Code](#).

History.

[I.C., § 41-5505](#), as added by 2000, ch. 472, § 17, p. 1602; am. 2003, ch. 267, § 4, p. 706; am. 2005, ch. 353, § 5, p. 1111; am. 2017, ch. 281, § 4, p. 733.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 281, rewrote subsections (1) and (2), which formerly read: “(1) Any individual carrier issuing an individual basic, standard, catastrophic A, catastrophic B, or HSA compatible health benefit plan as provided in this chapter shall be reinsured by the pool to the level of coverage provided in the plan and shall be liable to the pool for the reinsurance premium. (2) (a) The pool shall not reimburse a reinsuring carrier with respect to the claims of a reinsured individual or dependent until the carrier has incurred an initial level of claims for such individual or dependent of five thousand dollars (\$5,000) in a calendar year for benefits covered by the pool. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next twenty-five thousand dollars (\$25,000) of benefit payments during a calendar year and the pool shall reinsure the remainder. (b) The board annually may adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the “Consumer Price Index for All Urban Consumers” of the department of labor, bureau of labor statistics, unless the board proposes and the director approves a lower adjustment factor”; and added subsection (6).

Effective Dates.

Section 5 of S.L. 2003, ch. 267 declared an emergency. Approved April 8, 2003.

§ 41-5506. Reinsurance premium rates. — (1) The board, as part of the plan of operation, shall establish a methodology for determining reinsurance premium rates to be charged reinsuring carriers to reinsure individuals under this chapter. The methodology shall include a system for classification of individuals that reflects the types of case characteristics commonly used by individual carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, subject to the approval of the director, which shall be set at levels which reasonably approximate gross premiums charged to individuals by individual carriers for health benefit plans. Rate adjustments under the provisions of this subsection shall not be subject to the provisions of [section 41-5206, Idaho Code](#).

(2) The board periodically shall review the methodology established under the provisions of subsection (1) of this section, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the pool. The board may propose changes to the methodology which shall be subject to the approval of the director.

(3) The board may consider adjustments to the reinsurance premium rates charged by the pool to reflect the use of effective cost containment and managed care arrangements.

History.

[I.C., § 41-5506](#), as added by 2000, ch. 472, § 17, p. 1602; am. 2017, ch. 281, § 5, p. 733.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 281, in subsection (1), inserted “reinsurance” near the middle of the first sentence and deleted “with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under the provisions of this chapter” from the end of the third sentence; and inserted “reinsurance” near the middle of subsection (3).

§ 41-5507. Premium rates for high risk pool plan coverage. — (1) For high risk pool plans issued prior to April 1, 2017, the board shall establish premium rates for coverage under the individual basic, standard, catastrophic A, catastrophic B, and HSA compatible high risk pool plans.

(2) Separate schedules of premium rates based on age, individual tobacco use, geography as defined by rule of the director, gender and benefit plan design shall apply for individual risks.

(3) The board, with the assistance of the director and in accordance with appropriate actuarial principles, shall determine a standard risk rate by using the average rates that individual standard risks in this state are charged by at least five (5) of the largest health insurance carriers providing individual health insurance coverage to residents of Idaho that is substantially similar to the coverage offered by each high risk pool plan. In determining the average rate or charges of those health insurance carriers, the rates charged by those carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits similar to those provided by each plan. The standard risk rates shall be established using reasonable actuarial techniques and shall reflect anticipated claims experience, expenses, and other appropriate risk factors for such coverage.

(4) Rates for plan coverage shall not be less than one hundred twenty-five percent (125%) nor more than one hundred fifty percent (150%) of rates established as applicable for individual standard risks pursuant to subsection (3) of this section.

(5) Carriers shall not issue high risk pool plans as defined in [section 41-5501\(9\), Idaho Code](#), after April 1, 2017.

History.

[I.C., § 41-5507](#), as added by 2000, ch. 472, § 17, p. 1602; am. 2005, ch. 353, § 6, p. 1111; am. 2017, ch. 281, § 6, p. 733.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 281, inserted “high risk pool” in the section heading; rewrote subsection (1), which formerly read: “The board shall establish premium rates for coverage under the individual basic, standard, catastrophic A, catastrophic B, and HSA compatible health benefit plan”; in subsection (3), inserted “high risk” near the end of the first sentence; and added subsection (5).

§ 41-5508. Assessments. — (1) Prior to March 1 of each year, the board shall determine and report to the director the pool's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses, and any premium tax funds appropriated to the pool pursuant to [section 41-406, Idaho Code](#).

(2) Any net loss for the year may be recouped by assessments of carriers.

(3)(a) For the assessment of March 1, 2001, and prior to March 1 of each succeeding year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the pool in the previous calendar year.

(b) The individual assessments shall be determined by multiplying net losses, if net earnings are negative, as defined by subsection (1) of this section, by a fraction, the numerator of which shall be the carrier's total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease, and hospital confinement indemnity in this state as reported in the carrier's reports filed pursuant to [section 41-5505\(4\) and \(5\), Idaho Code](#), including reinsurance by way of excess or stop loss coverage, and the denominator of which shall be the total premiums earned in the preceding calendar year from all health benefit plans and policies or certificates of insurance for specific disease and hospital confinement indemnity in this state, including reinsurance by way of excess or stop loss coverage.

(4) If assessments exceed net losses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

(5) Each carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carriers with the director.

(6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(7) A carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment if the director determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving the deferment shall remain liable to the pool for the amount deferred and shall be prohibited from reinsuring any individuals with the pool until such time as it pays the assessments.

History.

I.C., § 41-5508, as added by 2000, ch. 472, § 17, p. 1602; am. 2017, ch. 281, § 7, p. 733.

STATUTORY NOTES

Amendments.

The 2017 amendment, by ch. 281, substituted “may be recouped” for “shall be recouped” near the middle of subsection (2).

§ 41-5509. Ceding eligibility. — (1) The pool shall provide reinsurance to any eligible individual who qualifies for reinsurance pursuant to this chapter if evidence is provided that such person has a qualifying high risk medical condition as defined by [section 41-5501\(8\), Idaho Code](#).

(2) Notwithstanding any other provision of this chapter, eligibility for continuation of coverage under COBRA shall not render a person ineligible for reinsurance coverage under this chapter.

(3) Reinsurance through the pool shall cease:

(a) On the first day of the month following the date a person is no longer a resident of this state;

(b) On the date coverage under the individual health benefit plan ends;

(c) Upon the death of the covered person;

(d) At the option of the board, thirty (30) days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

(4) Reinsurance for a person who ceases to meet the eligibility requirements of this chapter may be terminated on the first day of the month following the date when the individual becomes ineligible.

History.

[I.C., § 41-5510](#), as added by 2000, ch. 472, § 17, p. 1602; am. 2004, ch. 285, § 4, p. 802; am. 2004, ch. 332, § 3, p. 988; am. 2005, ch. 71, § 1, p. 247; am. 2005, ch. 353, § 8, p. 1111; am. 2008, ch. 297, § 2, p. 832; am. and redesign. 2017, ch. 281, § 9, p. 733.

STATUTORY NOTES

Prior Laws.

Former § 41-5509, Standards for agents, which comprised [I.C., § 41-5509](#), as added by 2000, ch. 472, § 17, p. 1602; am. 2005, ch. 353, § 7, p. 111, was repealed by S.L. 2017, ch. 281, § 8, effective July 1, 2017.

Amendments.

This section was amended by two 2004 acts which appear to be compatible and have been compiled together.

The 2004 amendment, by ch. 285, in subsections (4)(c) and (4)(d), deleted “defined” preceding “eligible individual.”

The 2004 amendment, by ch. 332, added subsection (1)(c).

This section was amended by two 2005 acts which appear to be compatible and have been compiled together.

The 2005 amendment, by ch. 71, added paragraph (1)(c) and present subsection (5), redesignating following affected provisions, inserted “coverage under title X of the consolidated omnibus budget reconciliation act of 1986, public law 99-272 (COBRA)” in paragraph (1)(d)(ii), and, in paragraph (4)(a), inserted “is not a federally eligible individual and” and “at a rate not exceeding the rate for the pool plan”.

The 2005 amendment, by ch. 353, inserted “and HSA compatible” in the introductory paragraph in subsection (1).

The 2008 amendment, by ch. 297, in the introductory paragraph in subsection (1), substituted “eligible individual person” for “eligible person”; added subsection (4) and redesignated the subsequent subsections accordingly; and inserted the exception in paragraph (5)(a).

The 2017 amendment, redesignated the section from § 41-5510 and rewrote the section to the extent that a detailed comparison is impracticable.

§ 41-5510. [Amended and Redesignated.]

STATUTORY NOTES

Compiler's Notes.

Former § 41-5510 was amended and redesignated as § 41-5509, pursuant to S.L. 2017, ch. 281, § 9, effective July 1, 2017.

Idaho Code § 41-5511

§ 41-5511. Design of products. [Repealed.]

Repealed by S.L. 2017, ch. 281, § 10, effective July 1, 2017.

History.

I.C., § 41-5511, as added by 2000, ch. 472, § 17, p. 1602; am. 2005, ch. 353, § 9, p. 1111.

Chapter 56

PROMPT PAYMENT OF CLAIMS

Sec.

41-5601. Definitions.

41-5602. Prompt payment of claims.

41-5603. Interest payments.

41-5604. Assignment.

41-5605. Exceptions.

41-5606. Penalties.

§ 41-5601. Definitions. — As used in this chapter:

(1) “Beneficiary” means a policyholder, subscriber, member, employer or other person who is eligible for benefits under a contract providing hospital, surgical, or medical expense coverage or a managed care organization policy or agreement under which a third party payer agrees to reimburse for covered health care services rendered to beneficiaries in accordance with the benefits contract.

(2) “Date of payment” means the date the payment is sent as indicated by the mail stamp on the envelope, by the insurer to the practitioner or facility or to the beneficiary in the event there is not a contract for direct payment by the insurer to the practitioner or facility, or, in the event of a wire or other electronic funds transfer, upon acceptance by the insurer’s bank of a payment order.

(3) “Department” means the department of insurance.

(4) “Director” means the director of the department of insurance.

(5) “Electronic claim” means a claim that is transmitted through the use of electronic media, which includes the internet, extranet, leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one (1) location to another using magnetic tape, disk or compact disk media. The claim shall contain the proper format and code sets in accordance with the applicable implementation specifications under [45 CFR 160 et seq.](#), and [45 CFR 162 et seq.](#)

(6) “Insurer” means any insurer that sells hospital, medical, long-term care, or vision insurance policies or certificates and managed care organizations. For the purpose of this chapter only, “insurer” also includes a third party administrator who makes payments to beneficiaries, practitioners or facilities on behalf of an insurer and a hospital or professional service corporation that provides hospital, medical, long-term care or vision health care services.

(7) “Practitioner or facility” means any physician, hospital or other person or facility licensed or otherwise authorized to furnish health care services.

(8) “Receipt of claim” means the date the claim is actually received by the insurer from the practitioner or facility or the beneficiary.

(9) “Submission of claim” means the date the claim is sent as indicated by the mail stamp on the envelope, by the beneficiary, practitioner or facility, to the insurer or the date an electronic claim is transmitted to an insurer.

History.

I.C., § 41-5601, as added by 2004, ch. 290, § 1, p. 812.

STATUTORY NOTES

Cross References.

Hospital and professional service corporations, § 41-3401 et seq.

Effective Dates.

Section 2 of S.L. 2004, ch. 290 provided: “This act shall be in full force and effect on and after January 1, 2005, and shall apply to those claims with a date of service on and after January 1, 2005.”

§ 41-5602. Prompt payment of claims. — (1) Except as otherwise specifically provided in this chapter, an insurer shall process a claim for payment for health care services rendered by a practitioner or facility to a beneficiary in accordance with this section.

(2) If a beneficiary, practitioner or facility submits an electronic claim to an insurer within thirty (30) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than thirty (30) days after receipt of the claim.

(3) If a beneficiary, practitioner or facility submits a paper claim for payment to an insurer within forty-five (45) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than forty-five (45) days after receipt of the claim.

(4) If an insurer denies the claim or needs additional information to process the claim, the insurer shall notify the practitioner or facility and the beneficiary in writing within thirty (30) days of receipt of an electronic claim or within forty-five (45) days of receipt of a paper claim. The notice shall state why the insurer denied the claim.

(5) If the claim was denied because more information was required to process the claim, the notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing. If the practitioner or facility submits the information and documentation identified by the insurer within thirty (30) days of receipt of the written notice, the insurer shall process and pay the claim within thirty (30) days of receipt of the additional information or, if appropriate, deny the claim.

(6) Any claim submitted pursuant to this chapter shall use the current procedural terminology (CPT) code in effect, as published by the American medical association, the international classification of disease [diseases] (ICD) code in effect, as published by the United States department of health and human services, or the healthcare common procedural coding system (HCPCS) code in effect, as published by the United States centers for medicaid and medicare services (CMS).

(7) This chapter shall not apply to claims submitted under policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, medicare supplement, disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

History.

I.C., § 41-5602, as added by 2004, ch. 290, § 1, p. 812; am. 2005, ch. 66, § 1, p. 231.

STATUTORY NOTES

Compiler's Notes.

For AMA's current procedural terminology (CPT), referred to in subsection (6), see <https://www.ama-assn.org/practice-management/find-coding-re-sources>.

For U.S. DHHS's international classification of diseases (ICD), referred to in subsection (6), see <http://www.cdc.gov/nchs/icd/icd10cm.htm#10update>.

For US Centers for medicaid and medicare services' (CMS) health care common procedural coding system (HCPCS), referred to in subsection (6), see <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/MedHCPCSGenInfo/>.

The bracketed insertion near the middle of subsection (6) was added by the compiler to correct the name of the referenced code.

Effective Dates.

Section 2 of S.L. 2004, ch. 290 provided: "This act shall be in full force and effect on and after January 1, 2005, and shall apply to those claims with a date of service on and after January 1, 2005."

§ 41-5603. Interest payments. — An insurer that fails to pay, request additional information or documentation or deny a claim from a beneficiary, practitioner or facility within the time periods established in this chapter shall pay interest at the contract statutory rate pursuant to [section 28-22-104, Idaho Code](#), on the unpaid amount of a claim that is determined to be due and owing. The interest shall accrue from the date payment was due, pursuant to the provisions of this chapter, until the claim is paid. Payment of any interest amount of less than four dollars (\$4.00) shall not be required. Insurers may add any interest due to a future payment to the beneficiary, practitioner or facility.

History.

[I.C., § 41-5603](#), as added by 2004, ch. 290, § 1, p. 812.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2004, ch. 290 provided: “This act shall be in full force and effect on and after January 1, 2005, and shall apply to those claims with a date of service on and after January 1, 2005.”

§ 41-5604. Assignment. — Nothing in this chapter requires an insurer to accept an assignment of payment by the beneficiary to the practitioner or facility.

History.

I.C., § 41-5604, as added by 2004, ch. 290, § 1, p. 812.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2004, ch. 290 provided: “This act shall be in full force and effect on and after January 1, 2005, and shall apply to those claims with a date of service on and after January 1, 2005.”

§ 41-5605. Exceptions. — (1) The time periods set forth in [section 41-5602, Idaho Code](#), shall not apply to claims that the insurer reasonably believes involve fraud or misrepresentation by the practitioner or facility or the beneficiary or to instances where the insurer has not been provided the information necessary to evaluate the claim after notice has been given requesting additional information by the insurer as required by [section 41-5602\(5\), Idaho Code](#).

(2) The time periods set forth in [section 41-5602, Idaho Code](#), shall not apply to claims that the insurer reasonably believes require medical records, including accident reports, for the purpose of investigating whether a claim is valid for subrogation, or the coordination of benefits payable by the insurer with benefits payable by another insurer or payable under federal or state law.

(3) An insurer is not required to comply with the time periods set forth in [section 41-5602, Idaho Code](#), if the insurer is in compliance with a contract with the practitioner or facility which specifies different payment requirements. Payments made within the time periods set forth in [section 41-5602, Idaho Code](#), for the purpose of this chapter, shall be deemed to be made in a reasonable and timely manner.

(4) An insurer is not required to comply with the periods set forth in [section 41-5602, Idaho Code](#), if the fee or premium entitling a beneficiary to insurance benefits has not been paid in full.

(5) An insurer is not required to comply with the time periods set forth in [section 41-5602, Idaho Code](#), if failure to comply is due to an act of God, bankruptcy, an act of a governmental authority responding to an act of God or emergency or the result of a strike, walkout or other labor dispute, or act of terrorism.

History.

[I.C., § 41-5605](#), as added by 2004, ch. 290, § 1, p. 812.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2004, ch. 290 provided: “This act shall be in full force and effect on and after January 1, 2005, and shall apply to those claims with a date of service on and after January 1, 2005.”

§ 41-5606. Penalties. — (1) The director shall enforce the provisions of this chapter and shall review and, if appropriate, investigate complaints received by the department related to noncompliance with the provisions of this chapter.

(2) If the director determines an insurer has violated the provisions of this chapter, the director may impose an administrative fine not to exceed five thousand dollars (\$5,000) based upon an enforcement action.

(3) The director shall not suspend or revoke an insurer's certificate of authority for violation of this chapter.

(4) No administrative penalty shall be imposed against an insurer under this chapter or any other provision of law for failure to comply with this chapter if, in the calendar year it has paid ninety-five percent (95%) or more of all claims subject to this chapter to or on behalf of beneficiaries within the time periods set forth in [section 41-5602, Idaho Code](#).

(5) This section shall not create a private cause of action by or on behalf of a beneficiary or practitioner or facility against an insurer.

History.

[I.C., § 41-5606](#), as added by 2004, ch. 290, § 1, p. 812.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2004, ch. 290 provided: "This act shall be in full force and effect on and after January 1, 2005, and shall apply to those claims with a date of service on and after January 1, 2005."

Chapter 57
INTERSTATE INSURANCE PRODUCT REGULATION
COMPACT

Sec.

41-5701. Preamble.

41-5702. Interstate Insurance Product Regulation Compact.

§ 41-5701. Preamble. — Pursuant to terms and conditions of this chapter, the state of Idaho seeks to join with other states and establish the interstate insurance product regulation compact, and thus become a member of the interstate insurance product regulation commission. The director of the department of insurance is hereby designated to serve as the representative of this state to the interstate insurance product regulation commission.

History.

I.C., § 41-5701, as added by 2005, ch. 79, § 1, p. 275.

STATUTORY NOTES

Compiler's Notes.

For interstate insurance product regulation commission, see:
<http://www.insurancecompact.org>.

§ 41-5702. Interstate Insurance Product Regulation Compact. — The “Interstate Insurance Product Regulation Compact” is hereby enacted into law and entered into by this state with any other states legally joining therein in the form substantially as follows:

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

ARTICLE I

PURPOSES

The purposes of this compact are, through means of joint and cooperative action among the compacting states:

(1) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

(2) To develop uniform standards for insurance products covered under the compact;

(3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one (1) or more compacting states;

(4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

(5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;

(6) To create the “Interstate Insurance Product Regulation Commission”;
and

(7) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II

DEFINITIONS

For purposes of this compact:

(1) “Advertisement” means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the rules and operating procedures of the commission.

(2) “Bylaws” means those bylaws established by the commission for its governance, or for directing or controlling the commission’s actions or conduct.

(3) “Compacting state” means any state which has enacted this compact legislation and which has not withdrawn pursuant to article XIV, section (1) of this compact, or been terminated pursuant to article XIV, section (2) of this compact.

(4) “Commission” means the “Interstate Insurance Product Regulation Commission” established by this compact.

(5) “Commissioner” means the chief insurance regulatory official of a state including, but not limited to, commissioner, superintendent, director or administrator.

(6) “Domiciliary state” means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(7) “Insurer” means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this act.

(8) “Member” means the person chosen by a compacting state as its representative to the commission, or his or her designee.

(9) “Noncompacting state” means any state which is not at the time a compacting state.

(10) “Operating procedures” means procedures promulgated by the commission implementing a rule, uniform standard or a provision of this compact.

(11) “Product” means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an insurer is authorized to issue.

(12) “Rule” means a statement of general or particular applicability and future effect promulgated by the commission, including a uniform standard developed pursuant to article VII of this compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the commission, which shall have the force and effect of law in the compacting states.

(13) “State” means any state, district or territory of the United States of America.

(14) “Third-party filer” means an entity that submits a product filing to the commission on behalf of an insurer.

(15) “Uniform standard” means a standard adopted by the commission for a product line, pursuant to article VII of this compact, and shall include all of the product requirements in aggregate; provided, that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable or against public policy as determined by the commission.

ARTICLE III

ESTABLISHMENT OF THE COMMISSION AND VENUE

(1) The compacting states hereby create and establish a joint public agency known as the “Interstate Insurance Product Regulation Commission.” Pursuant to article IV, the commission will have the power to

develop uniform standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable uniform standards; provided, it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the state where filed.

(2) The commission is a body corporate and politic, and an instrumentality of the compacting states.

(3) The commission is solely responsible for its liabilities except as otherwise specifically provided in this compact.

(4) Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located.

ARTICLE IV

POWERS OF THE COMMISSION

The commission shall have the following powers:

(1) To promulgate rules, pursuant to article VII of this compact, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this compact;

(2) To exercise its rulemaking authority and establish reasonable uniform standards for products covered under the compact, and advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the commission, provided that a compacting state shall have the right to opt out of such uniform standard pursuant to article VII, to the extent and in the manner provided in this compact, and, provided further, that any uniform standard established by the commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the national

association of insurance commissioners' (NAIC) long-term care insurance model act and long-term care insurance model regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the NAIC long-term care insurance model act or long-term care insurance model regulation adopted by the NAIC require amending of the uniform standards established by the commission for long-term care insurance products;

(3) To receive and review in an expeditious manner products filed with the commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the compact;

(4) To receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the commission, and give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long-term care insurance products, the commission shall have the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the compact;

(5) To exercise its rulemaking authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the commission.

(6) To promulgate operating procedures, pursuant to article VII of this compact, which shall be binding in the compacting states to the extent and in the manner provided in this compact;

(7) To bring and prosecute legal proceedings or actions in its name as the commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(9) To establish and maintain offices;

(10) To purchase and maintain insurance and bonds;

(11) To borrow, accept or contract for services of personnel, including, but not limited to, employees of a compacting state;

(12) To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the compact, and determine their qualifications; and to establish the commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the commission shall strive to avoid any appearance of impropriety;

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the commission shall strive to avoid any appearance of impropriety;

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

(16) To remit filing fees to compacting states as may be set forth in the bylaws, rules or operating procedures;

(17) To enforce compliance by compacting states with rules, uniform standards, operating procedures and bylaws;

(18) To provide for dispute resolution among compacting states;

(19) To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this compact;

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state

insurance departments;

(21) To establish a budget and make expenditures;

(22) To borrow money;

(23) To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the bylaws;

(24) To provide and receive information from, and to cooperate with law enforcement agencies;

(25) To adopt and use a corporate seal; and

(26) To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of the business of insurance.

ARTICLE V

ORGANIZATION OF THE COMMISSION

(1) Membership, Voting and Bylaws.

(a) Each compacting state shall have and be limited to one (1) member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which he or she shall be appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

(b) Each member shall be entitled to one (1) vote and shall have an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the commission with respect to the promulgation of

a uniform standard shall be effective unless two-thirds (2/3) of the members vote in favor thereof.

(c) The commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the compact, including, but not limited to:

- (i) Establishing the fiscal year of the commission;
- (ii) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee;
- (iii) Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees; and (ii) governing any general or specific delegation of any authority or function of the commission;
- (iv) Providing reasonable procedures for calling and conducting meetings of the commission that consists of a majority of commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting in toto or in part. As soon as practicable, the commission must make public: (i) a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed; and (ii) votes taken during such meeting;
- (v) Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the commission;
- (vi) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the commission;
- (vii) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

(viii) Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment and/or reserving of all of its debts and obligations.

(d) The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compacting states.

(2) Management Committee, Officers and Personnel.

(a) A management committee comprising no more than fourteen (14) members shall be established as follows:

(i) One (1) member from each of the six (6) compacting states with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

(ii) Four (4) members from those compacting states with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

(iii) Four (4) members from those compacting states with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the bylaws.

(b) The management committee shall have such authority and duties as may be set forth in the bylaws including, but not limited to:

(i) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission;

(ii) Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform

standard; provided that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds (2/3) of the members of the management committee;

(iii) Overseeing the offices of the commission; and

(iv) Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the commission.

(c) The commission shall elect annually officers from the management committee, with each having such authority and duties, as may be specified in the bylaws.

(d) The management committee may, subject to the approval of the commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the commission may deem appropriate. The executive director shall serve as secretary to the commission, but shall not be a member of the commission. The executive director shall hire and supervise such other staff as may be authorized by the commission.

(3) Legislative and Advisory Committees.

(a) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the commission, including the management committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

(b) The commission shall establish two (2) advisory committees, one (1) of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

(c) The commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

(4) Corporate Records of the Commission. The commission shall maintain its corporate books and records in accordance with the bylaws.

(5) Qualified Immunity, Defense and Indemnification.

(a) The members, officers, executive director, employees and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI

MEETINGS AND ACTS OF THE COMMISSION

(1) The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

(2) Each member of the commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(3) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

ARTICLE VII

RULES AND OPERATING PROCEDURES: RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

(1) Rulemaking Authority. The commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this compact. Notwithstanding the foregoing, in the event the commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this act, or the powers granted hereunder, then such an action by the commission shall be invalid and have no force and effect.

(2) Rulemaking Procedure. Rules and operating procedures shall be made pursuant to a rulemaking process that conforms to the model state administrative procedure act of 1981 as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committee(s) in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The commission in

adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(3) Effective Date and Opt Out of a Uniform Standard. A uniform standard shall become effective ninety (90) days after its promulgation by the commission or such later date as the commission may determine; provided, however, that a compacting state may opt out of a uniform standard as provided in this article. “Opt out” shall be defined as any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure or amendment.

(4) Opt Out Procedure. A compacting state may opt out of a uniform standard, either by legislation or regulation duly promulgated by the insurance department under the compacting state’s administrative procedure act. If a compacting state elects to opt out of a uniform standard by regulation, it must: (a) give written notice to the commission no later than ten (10) business days after the uniform standard is promulgated, or at the time the state becomes a compacting state; and (b) find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state which warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this act; and (ii) the presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in

this compact. Such an opt out shall be effective at the time of enactment of this compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

(5) Effect of Opt Out. If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time as the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under article XIV of this compact for withdrawals.

(6) Stay of Uniform Standard. If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the commission, at least fifteen (15) days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the compacting state can show extraordinary circumstances which warrant a continuance of the stay including, but not limited to, the existence of a legal challenge which prevents the compacting state from opting out. A stay may be terminated by the commission upon notice that the rulemaking process has been terminated.

(7) Not later than thirty (30) days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure; provided, that the filing of such a petition shall not

stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.

ARTICLE VIII

COMMISSION RECORDS AND ENFORCEMENT

(1) The commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals' and insurers' trade secrets. The commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(2) Except as to privileged records, data and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data or information to the commission; provided, that disclosure to the commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this act, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the commission shall remain confidential after such information is provided to any commissioner.

(3) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any noncomplying compacting state in writing of its noncompliance with commission bylaws, rules or operating procedures. If a noncomplying compacting state fails to remedy

its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in article XIV of this compact.

(4) The commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following provisions:

(a) With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission.

(b) Before a commissioner may bring an action for violation of any provision, standard or requirement of the compact relating to the content of an advertisement not approved or certified to the commission, the commission, or an authorized commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the insurer, opportunity for hearing or disclosure of requests for authorization or records of the commission's action on such requests.

ARTICLE IX

DISPUTE RESOLUTION

The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and which may arise between two (2) or more compacting states, or between compacting states and noncompacting states, and the commission shall promulgate an operating procedure providing for resolution of such disputes.

ARTICLE X

PRODUCT FILING AND APPROVAL

(1) Insurers and third-party filers seeking to have a product approved by the commission shall file the product with, and pay applicable filing fees to, the commission. Nothing in this act shall be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

(2) The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the commission shall promulgate rules to establish conditions and procedures under which the commission will provide public access to product filing information. In establishing such rules, the commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

(3) Any product approved by the commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

ARTICLE XI

REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

(1) Not later than thirty (30) days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall promulgate rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse

of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with article III, section (4) of this compact.

(2) The commission shall have authority to monitor, review and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in section (1) above.

ARTICLE XII

FINANCE

(1) The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the national association of insurance commissioners, compacting states and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of its duties shall not be compromised.

(2) The commission shall collect a filing fee from each insurer and third-party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

(3) The commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in article VII of this compact.

(4) The commission shall be exempt from all taxation in and by the compacting states.

(5) The commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(6) The commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all

funds under its control. The internal financial accounts of the commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports including the system of internal controls and procedures of the commission shall be audited annually by an independent certified public accountant. Upon the determination of the commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the commission. The commission shall make an annual report to the governor and legislature of the compacting states, which shall include a report of the independent audit. The commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state upon request, provided however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals' and insurers' proprietary information, including trade secrets, shall remain confidential.

(7) No compacting state shall have any claim to or ownership of any property held by or vested in the commission or to any commission funds held pursuant to the provisions of this compact.

ARTICLE XIII

COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT

(1) Any state is eligible to become a compacting state.

(2) The compact shall become effective and binding upon legislative enactment of the compact into law by two (2) compacting states; provided, the commission shall become effective for purposes of adopting uniform standards for reviewing, and giving approval or disapproval of, products filed with the commission that satisfy applicable uniform standards only after twenty-six (26) states are compacting states or, alternatively, by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state.

(3) Amendments to the compact may be proposed by the commission for enactment by the compacting states. No amendment shall become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law.

ARTICLE XIV

WITHDRAWAL, DEFAULT AND TERMINATION

(1) Withdrawal.

(a) Once effective, the compact shall continue in force and remain binding upon each and every compacting state; provided, that a compacting state may withdraw from the compact (“withdrawing state”) by enacting a statute specifically repealing the statute which enacted the compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in paragraph (e) of this section.

(c) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state.

(d) The commission shall notify the other compacting states of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

(e) The withdrawing state is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extends beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission’s approval of products and advertisement prior to the effective date of withdrawal shall continue to

be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the compact.

(2) Default.

(a) If the commission determines that any compacting state has at any time defaulted (“defaulting state”) in the performance of any of its obligations or responsibilities under this compact, the bylaws or duly promulgated rules or operating procedures; then, after notice and hearing as set forth in the bylaws, all rights, privileges and benefits conferred by this compact on the defaulting state shall be suspended from the effective date of default as fixed by the commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state’s suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state shall be terminated from the compact and all rights, privileges and benefits conferred by this compact shall be terminated from the effective date of termination.

(b) Product approvals by the commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to section (1) of this article.

(c) Reinstatement following termination of any compacting state requires a reenactment of the compact.

(3) Dissolution of Compact.

(a) The compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the compact to one (1) compacting state.

(b) Upon the dissolution of this compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

ARTICLE XV

SEVERABILITY AND CONSTRUCTION

(1) The provisions of this compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(2) The provisions of this compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) Other Laws.

(a) Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in paragraph (b) of this section.

(b) For any product approved or certified to the commission, the rules, uniform standards and any other requirements of the commission shall constitute the exclusive provisions applicable to the content, approval and certification of such products. For advertisement that is subject to the commission's authority, any rule, uniform standard or other requirement of the commission which governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to

breach of contract, tort, or other laws not specifically directed to the content of the product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state including, but not limited to, maintaining any actions or proceedings, as authorized by law.

(c) All insurance products filed with individual states shall be subject to the laws of those states.

(2) Binding Effect of this Compact.

(a) All lawful actions of the commission, including all rules and operating procedures promulgated by the commission, are binding upon the compacting states.

(b) All agreements between the commission and the compacting states are binding in accordance with their terms.

(c) Upon the request of a party to a conflict over the meaning or interpretation of commission actions, and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(d) In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the commission shall be ineffective as to that compacting state, and those obligations, duties, powers or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this compact becomes effective.

History.

I.C., § 41-5702, as added by 2005, ch. 79, § 1, p. 275.

STATUTORY NOTES

Compiler's Notes.

Pursuant to the requirements of Section 2 of Article XIII, that the compact be adopted by 26 states or by states representing 40% of the

premium volume for certain insurances, the interstate insurance product regulation compact came into existence in May 2006. See www.insurancecompact.org.

For more information on the national association of insurance commissioners, see <http://naic.org/>.

The words enclosed in parentheses so appeared in the law as enacted.

Chapter 58

PUBLIC ADJUSTER LICENSING ACT

Sec.

- 41-5801. Purpose and scope.
- 41-5802. Definitions.
- 41-5803. License required.
- 41-5804. Exceptions to licensing.
- 41-5805. Application for license.
- 41-5806. License qualifications.
- 41-5807. Examination.
- 41-5808. Exemptions from examination.
- 41-5809. Nonresident license reciprocity.
- 41-5810. License.
- 41-5811. License denial, nonrenewal or revocation.
- 41-5812. Bond or letter of credit.
- 41-5813. Continuing education.
- 41-5814. Public adjuster fees.
- 41-5815. Contract between public adjuster and insured.
- 41-5816. Escrow or trust accounts.
- 41-5817. Record retention.
- 41-5818. Standards of conduct of public adjuster.
- 41-5819. Reporting of actions.
- 41-5820. Rules.
- 41-5821. Severability.

§ 41-5801. Purpose and scope. — This chapter governs the qualifications and procedures for the licensing of public adjusters. It specifies the duties of and restrictions on public adjusters, which include limiting their licensure to assisting insureds in first party claims.

History.

I.C., § 41-5801, as added by 2008, ch. 179, § 1, p. 532.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5802. Definitions. — As used in this chapter:

(1) “Business entity” means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(2) “Fingerprints” means an impression of the lines on the finger taken for purpose of identification. The impression may be electronic or in ink converted to electronic format.

(3) “Home state” means the District of Columbia or any state or territory of the United States in which the public adjuster’s principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the home state.

(4) “Individual” means a natural person.

(5) “Person” means an individual or a business entity.

(6) “Public adjuster” means any person who, for compensation or any other thing of value on behalf of the insured:

(a) Acts or aids, solely in relation to first party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(b) Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(c) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first party claims for losses or damages arising out of policies of insurance that insure real or personal property

for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.

History.

I.C., § 41-5802, as added by 2008, ch. 179, § 1, p. 532.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5803. License required. — (1) A person shall not act or hold himself out as a public adjuster in this state unless the person is licensed as a public adjuster in accordance with this chapter.

(2) A person licensed as a public adjuster shall not misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster unless so appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster is prohibited from charging that specific claimant a fee when appointed by the insurer and the appointment is accepted by the public adjuster.

History.

I.C., § 41-5803, as added by 2008, ch. 179, § 1, p. 533.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of **section 41-5805, Idaho Code**, do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5804. Exceptions to licensing. — Notwithstanding [section 41-5803, Idaho Code](#), a license as a public adjuster shall not be required of the following:

- (1) An attorney admitted to practice in this state, when acting in his or her professional capacity as an attorney;
- (2) A producer licensed in Idaho who acts only on behalf of his or her own insured and does not hold himself or herself out to the public as a public adjuster;
- (3) A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;
- (4) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster including, but not limited to, photographers, estimators, private investigators, engineers and handwriting experts;
- (5) A licensed health care provider, or employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient; or
- (6) A person who settles subrogation claims between insurers.

History.

[I.C., § 41-5804](#), as added by 2008, ch. 179, § 1, p. 533.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5805. Application for license. [Effective upon a state's participation in NAIC's central repository — See note below.] — (1) A person applying for a public adjuster license shall make application to the department on an application form prescribed by the department.

(2) The applicant shall declare under penalty of perjury and under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the applicant's knowledge and belief.

(3) In order to make a determination of license eligibility, the department is authorized to require fingerprints of applicants and submit the fingerprints and the fee required to perform the criminal history record checks to the Idaho state police and the federal bureau of investigation (FBI) for state and national criminal history record checks; the department shall require a criminal history record check on each applicant in accordance with this chapter. The department shall require each applicant to submit a full set of fingerprints in order for the department to obtain and receive national criminal history records from the FBI criminal justice information services division.

(a) The department may contract for the collection, transmission and resubmission of fingerprints required under this section. If the department does so, the fee for collecting, transmitting and retaining fingerprints shall be payable directly to the contractor by the person. The department may agree to a reasonable fingerprinting fee to be charged by the contractor.

(b) The department is authorized to receive criminal history record information in lieu of the Idaho state police that submitted the fingerprints to the FBI.

History.

I.C., § 41-5805, as added by 2008, ch. 179, § 1, p. 533.

STATUTORY NOTES

Cross References.

Idaho state police, § 67-2901 et seq.

Compiler's Notes.

For criminal justice information services division of the FBI, referred to at the end of the introductory paragraph in subsection (3), see <http://www.fbi.gov/hq/cjisd/cjis.htm>.

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided, however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5806. License qualifications. — (1) Before issuing a public adjuster license to an applicant under this section, the department shall find that the applicant:

- (a) Is at least eighteen (18) years of age;
- (b) Is eligible to designate this state as his or her home state or is a nonresident who is eligible for a license under [section 41-5809, Idaho Code](#);
- (c) Has successfully passed the public adjuster examination;
- (d) Has not committed any act that is a ground for denial, suspension or revocation of a license as set forth in [section 41-5811, Idaho Code](#);
- (e) Is trustworthy, reliable, and of good reputation, evidence of which may be determined by the department;
- (f) Is financially responsible to exercise the license and has provided proof of financial responsibility as required in [section 41-5812, Idaho Code](#);
- (g) Has paid the fees set forth by rule adopted pursuant to [section 41-401, Idaho Code](#); and
- (h) Maintains an office in the home state of residence with public access by reasonable appointment and/or regular business hours. This includes a designated office within a home state of residence.

(2) In addition to satisfying the requirements of subsection (1), when applicable, a business entity shall:

- (a) Designate a licensed individual public adjuster responsible for the business entity's compliance with the insurance laws and rules of this state;
- (b) Designate only licensed individual public adjusters to exercise the business entity's license; and
- (c) The department may require any documents reasonably necessary to verify the information contained in the application.

History.

I.C., § 41-5806, as added by 2008, ch. 179, § 1, p. 534.

STATUTORY NOTES**Effective Dates.**

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5807. Examination. — (1) An individual applying for a public adjuster license under this chapter shall pass a written examination unless exempt pursuant to [section 41-5808, Idaho Code](#). The examination shall test the knowledge of the individual concerning the duties and responsibilities of a public adjuster and the insurance laws and rules of this state. Examinations required by this section shall be developed and conducted under rules prescribed by the department.

(2) The department may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth by rule of the department.

(3) Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the department in an amount set by rule of the department adopted pursuant to [section 41-401, Idaho Code](#).

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

History.

[I.C., § 41-5807](#), as added by 2008, ch. 179, § 1, p. 534.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5808. Exemptions from examination. — (1) An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in another state based on a public adjuster examination shall not be required to complete any prelicensing examination. This exemption is only available if the person is currently licensed in that state or if the person applies for a license in this state within ninety (90) days of cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records or records maintained by the national association of insurance commissioners (NAIC), its affiliates, or subsidiaries, indicate that the public adjuster is or was licensed and in good standing.

(2) A person licensed as a public adjuster in another state based on a public adjuster examination who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to [section 41-5805, Idaho Code](#). No prelicensing examination shall be required of that person to obtain a public adjuster license.

(3) An individual who applies for a public adjuster license in this state who was previously licensed as a public adjuster in this state shall not be required to complete any prelicensing examination. This exemption is only available if the application is received within twelve (12) months of the cancellation of the applicant's previous license in this state and if, at the time of cancellation, the applicant was in good standing in this state.

(4) A licensed individual who moves and establishes residency in this state must apply for a resident license within ninety (90) days of establishing residency here and must relinquish his or her resident license in the former home state.

History.

[I.C., § 41-5808](#), as added by 2008, ch. 179, § 1, p. 535.

STATUTORY NOTES

Compiler's Notes.

As to national association of insurance commissioners, referred to in subsection (1), see *<http://naic.org>*.

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of **section 41-5805, Idaho Code**, do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5809. Nonresident license reciprocity. — (1) Unless denied licensure pursuant to sections 41-5810 or 41-5811, Idaho Code, a nonresident person shall receive a nonresident public adjuster license if:

- (a) The person is currently licensed as a resident public adjuster and in good standing in his or her home state;
- (b) The person has submitted the proper request for licensure, has paid the fees required by rule of the department adopted pursuant to [section 41-5806\(1\)\(g\), Idaho Code](#), and has provided proof of financial responsibility as required in [section 41-5812, Idaho Code](#);
- (c) The person has submitted or transmitted to the department the appropriate completed application for licensure; and
- (d) The person's home state awards nonresident public adjuster licenses to residents of this state on the same basis.

(2) The department may verify the public adjuster's licensing status through the producer database maintained by the NAIC, its affiliates, or subsidiaries.

(3) As a condition to continuation of a public adjuster license issued under this section, the licensee shall maintain a resident public adjuster license in his or her home state. The nonresident public adjuster license issued under this section shall terminate and be surrendered immediately to the department if the home state public adjuster license terminates for any reason, unless the public adjuster has been issued a license as a resident public adjuster in his or her new home state. Notification to the state or states where a nonresident license is issued must be made as soon as possible, within thirty (30) days of the change in new state resident license. The licensee shall include new and old addresses. A new state resident license is required for nonresident licenses to remain valid. The new state resident license must have reciprocity with the licensing nonresident state(s) for the nonresident license not to terminate.

History.

[I.C., § 41-5809](#), as added by 2008, ch. 179, § 1, p. 535.

STATUTORY NOTES

Compiler's Notes.

As to national association of insurance commissioners (NAIC), referred to in subsection (2), see *<http://naic.org>*.

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of **section 41-5805, Idaho Code**, do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5810. License. — (1) Unless denied licensure under this chapter, persons who have met the requirements of this chapter shall be issued a public adjuster license.

(2) A public adjuster license shall remain in effect unless revoked, terminated or suspended as long as the request for renewal and the fee set forth in the rule promulgated under [section 41-5806\(1\)\(g\), Idaho Code](#), is paid and any other requirements for license renewal are met by the due date.

(3) The licensee shall inform the department by any means acceptable to the department of a change of address, change of legal name, or change of information submitted on the application within thirty (30) days of the change.

(4) A public adjuster who allows his or her license to lapse may, within twelve (12) months from the due date of the renewal, reinstate his or her public adjuster license upon the department's receipt of the request for renewal, payment of a penalty in the amount of double the unpaid renewal fee and certification that all continuing education requirements have been met. The new public adjuster license shall be effective the date the department receives all of the above stated items required for reinstatement.

(5) A licensed public adjuster who is unable to comply with license renewal procedures due to military service, a long-term medical disability or some other extenuating circumstance, may request a waiver of those procedures. The public adjuster may also request a waiver of any examination requirement, fine or other sanction imposed for failure to comply with renewal procedures.

(6) The license shall contain the licensee's name, city and state of business address, license number, the date of issuance, the expiration date and any other information the department deems necessary.

(7) In order to assist in the performance of the department's duties, the department may contract with nongovernmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform

any ministerial functions, including the collection of fees and data, related to licensing that the department may deem appropriate.

History.

I.C., § 41-5810, as added by 2008, ch. 179, § 1, p. 536.

STATUTORY NOTES

Compiler's Notes.

As to national association of insurance commissioners (NAIC), referred to in subsection (7), see *<http://naic.org>*.

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5811. License denial, nonrenewal or revocation. — (1) The department may place on probation, suspend, revoke or refuse to issue or renew a public adjuster's license or may levy a civil penalty in accordance with [section 41-1016, Idaho Code](#), or any combination of actions, for any one (1) or more of the following causes:

- (a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;
- (b) Violating any insurance laws, or violating any rule, regulation, subpoena or order of the department or of another state's insurance department;
- (c) Obtaining or attempting to obtain a license through misrepresentation or fraud;
- (d) Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance business;
- (e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;
- (f) Having been convicted of a crime that is deemed relevant in accordance with [section 67-9411\(1\), Idaho Code](#), or that evidences dishonesty, a lack of integrity and financial responsibility, or an unfitness and inability to provide acceptable service to the consuming public;
- (g) Having admitted to or been found to have committed any insurance unfair trade practice or insurance fraud;
- (h) Using fraudulent, coercive or dishonest practices; or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;
- (i) Having an insurance license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;
- (j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Cheating, including improperly using notes or any other reference material, to complete an examination for an insurance license;

(l) Knowingly accepting insurance business from an individual who is not licensed but who is required to be licensed by the department;

(m) Failing to comply with an administrative or court order imposing a child support obligation, provided however, that nothing in this provision shall be deemed to abrogate or modify chapter 14, title 7, Idaho Code; or

(n) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(2) The license of a business entity may be suspended, revoked or refused if the department finds, after hearing, that an individual licensee's violation was known or should have been known by one (1) or more of the partners, officers or managers acting on behalf of the business entity and the violation was neither reported to the department nor corrective action taken.

(3) In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine or administrative penalty according to [section 41-1016, Idaho Code](#).

(4) The department shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter and title 41, Idaho Code, against any person who is under investigation for or charged with a violation of this chapter or title 41, Idaho Code, even if the person's license or registration has been surrendered or has lapsed by operation of law.

History.

[I.C., § 41-5811](#), as added by 2008, ch. 179, § 1, p. 536; am. 2020, ch. 175, § 10, p. 500.

STATUTORY NOTES

Amendments.

The 2020 amendment, by ch. 175, substituted “convicted of a crime that is deemed relevant in accordance with section 67-9411(1), Ida Code or that evidences dishonesty” for “convicted of a felony, or a misdemeanor which

evidences bad moral character, dishonesty” near the beginning of paragraph (1)(f).

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC’s central repository for the purpose of obtaining criminal background information.

§ 41-5812. Bond or letter of credit. — Prior to issuance of a license as a public adjuster and for the duration of the license, the applicant shall secure evidence of financial responsibility in a format prescribed by the department through a security bond or irrevocable letter of credit.

(1) A surety bond executed and issued by an insurer authorized to issue surety bonds in this state, which bond: (a) Shall be in the minimum amount of twenty thousand dollars (\$20,000);

(b) Shall be in favor of this state and shall specifically authorize recovery by the department on behalf of any person in this state who sustained damages as the result of erroneous acts, a failure to act, conviction of fraud, or conviction of unfair practices in his or her capacity as a public adjuster; and (c) Shall not be terminated unless at least thirty (30) days' prior written notice will have been filed with the department and given to the licensee.

(2) An irrevocable letter of credit issued by a qualified financial institution, which letter of credit: (a) Shall be in the minimum amount of twenty thousand dollars (\$20,000);

(b) Shall be to an account within the department and subject to lawful levy of execution on behalf of any person to whom the public adjuster has been found to be legally liable as the result of erroneous acts, a failure to act, fraudulent acts, or unfair practices in his or her capacity as a public adjuster; and (c) Shall not be terminated unless at least thirty (30) days' prior written notice will have been filed with the department and given to the licensee.

(3) The issuer of the evidence of financial responsibility shall notify the department upon termination of the bond or letter of credit, unless otherwise directed by the department.

(4) The department may ask for the evidence of financial responsibility at any time deemed relevant.

(5) The authority to act as a public adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

History.

I.C., § 41-5812, as added by 2008, ch. 179, § 1, p. 537.

STATUTORY NOTES**Effective Dates.**

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5813. Continuing education. — (1) An individual, who holds a public adjuster license and who is not exempt under subsection (2) of this section, shall satisfactorily complete a minimum of twenty-four (24) hours of continuing education courses, including three (3) hours of law or ethics, reported on a biennial basis in conjunction with the license renewal cycle.

(2) This section shall not apply to:

(a) Licensees not licensed for one (1) full year prior to the end of the applicable continuing education biennium; or

(b) Licensees holding nonresident public adjuster licenses who have met the continuing education requirements of their home state and whose home state gives credit to residents of this state on the same basis.

(3) Only continuing education courses approved by the department shall be used to satisfy the continuing education requirement of subsection (1) of this section.

(4) Failure of the licensee to comply with the applicable education requirement by the expiration date of the license shall be grounds for the director to refuse to continue any such license. The licensee may reinstate his or her license by submitting proof of all education requirements within ninety (90) days from the date of expiration of the license and by submitting an additional administrative penalty of one hundred dollars (\$100) for a delinquency of one (1) day to thirty (30) days, two hundred dollars (\$200) for a delinquency of thirty-one (31) days to sixty (60) days, and three hundred dollars (\$300) for a delinquency of sixty-one (61) days to ninety (90) days. Following the ninetieth day from the date of nonrenewal of the license and up to one (1) year from the nonrenewal date, the licensee must complete all requirements for licensure including retesting, submission of a new application and payment of all new licensing fees. In addition, the individual must submit proof of completion of the required education requirements from the licensing period in which the license was terminated. After the license has been expired for one (1) year or more, the individual must reapply and retest as a new applicant.

History.

I.C., § 41-5813, as added by 2008, ch. 179, § 1, p. 538.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5814. Public adjuster fees. — (1) A public adjuster shall not pay a commission, service fee or other valuable consideration to a person for investigating or settling claims in this state if that person is required to be licensed under this chapter and is not so licensed.

(2) A person shall not accept a commission, service fee or other valuable consideration for investigating or settling claims in this state if that person is required to be licensed under this chapter and is not so licensed.

(3) A public adjuster may pay or assign commission, service fees or other valuable consideration to persons who do not investigate or settle claims in this state, unless the payment would violate [section 41-1314, Idaho Code](#).

History.

[I.C., § 41-5814](#), as added by 2008, ch. 179, § 1, p. 539.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5815. Contract between public adjuster and insured. — (1) Public adjusters shall ensure that all contracts for their services are in writing and contain the following terms:

- (a) Legible full name of the adjuster signing the contract, as specified in department records;
- (b) Permanent home state business address and phone number;
- (c) Department license number;
- (d) Title of “public adjuster contract”;
- (e) Insured’s full name, street address, insurance company name and policy number, if known, or upon notification;
- (f) Description of the loss and its location, if applicable;
- (g) Description of services to be provided to the insured;
- (h) Signatures of the public adjuster and the insured;
- (i) Date contract was signed by the public adjuster and date the contract was signed by the insured;
- (j) Attestation language stating that the public adjuster is fully bonded pursuant to state law; and
- (k) Full salary, fee, commission, compensation or other considerations the public adjuster is to receive for services.

(2) The contract may specify that the public adjuster shall be named as a co-payee on an insurer’s payment of a claim.

- (a) If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified.
- (b) Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type, with dollar estimates set forth in the contract and with any additional expenses first approved by the insured.

(3) If the insurer, not later than seventy-two (72) hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall:

(a) Not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim;

(b) Inform the insured that the loss recovery amount might not be increased by insurer; and

(c) Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(4) A public adjuster shall provide the insured a written disclosure concerning any direct or indirect financial interest that the public adjuster has with any other party that is involved in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured including, but not limited to, any ownership of, other than as a minority stockholder, or any compensation expected to be received from, any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop, or any other firm that provides estimates for work, or that performs any work, in conjunction with damages caused by the insured loss on which the public adjuster is engaged. The word "firm" shall include any person.

(5) A public adjuster contract may not contain any contract term that:

(a) Allows the public adjuster's percentage fee to be collected when money is due from an insurance company, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company, rather than as a percentage of each check issued by an insurance company;

(b) Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;

(c) Imposes collection costs or late fees; or

(d) Precludes a public adjuster from pursuing civil remedies.

(6) Prior to the signing of the contract the public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states:

(a) Property insurance policies obligate the insured to present a claim to his or her insurance company for consideration. There are three (3) types of adjusters that could be involved in that process. The definitions of the three types are as follows:

(i) “Company adjuster” means the insurance adjusters are employees of an insurance company. They represent the interest of the insurance company and are paid by the insurance company. They will not charge you a fee.

(ii) “Independent adjuster” means the insurance adjusters are hired on a contract basis by an insurance company to represent the insurance company’s interest in the settlement of the claim. They are paid by your insurance company. They will not charge you a fee.

(iii) “Public adjuster” means the insurance adjusters do not work for any insurance company. They work for the insured to assist in the preparation, presentation and settlement of the claim. The insured hires them by signing a contract agreeing to pay them a fee or commission based on a percentage of the settlement or other method of compensation.

(b) The insured is not required to hire a public adjuster to help the insured meet his or her obligations under the policy, but has the right to do so.

(c) The insured has the right to initiate direct communications with the insured’s attorney, the insurer, the insurer’s adjuster, and the insurer’s attorney, or any other person regarding the settlement of the insured’s claim.

(d) The public adjuster is not a representative or employee of the insurer.

(e) The salary, fee, commission or other consideration is the obligation of the insured, not the insurer.

(7) The contract shall be executed in duplicate to provide an original contract to the public adjuster, and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the department.

(8) The public adjuster shall provide the insurer a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

(9) The public adjuster shall give the insured written notice of the insured's rights as provided in this section.

(10) The insured has the right to rescind the contract within three (3) business days after the date the contract was signed. The rescission shall be in writing and mailed or delivered to the public adjuster at the address in the contract within the three (3) business day period.

(11) If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured within twenty-eight (28) days following the receipt by the public adjuster of the cancellation notice.

History.

I.C., § 41-5815, as added by 2008, ch. 179, § 1, p. 539.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5816. Escrow or trust accounts. — A public adjuster who receives, accepts or holds any funds on behalf of an insured, towards the settlement of a claim for loss or damage, shall deposit the funds in a noninterest bearing escrow or trust account in a financial institution that is insured by an agency of the federal government in the public adjuster's home state or where the loss occurred.

History.

I.C., § 41-5816, as added by 2008, ch. 179, § 1, p. 541.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5817. Record retention. — (1) A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this section shall include the following:

- (a) Name of the insured;
- (b) Date, location and amount of the loss;
- (c) Copy of the contract between the public adjuster and insured;
- (d) Name of the insurer, amount, expiration date and number of each policy carried with respect to the loss;
- (e) Itemized statement of the insured's recoveries;
- (f) Itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss;
- (g) A register of all moneys received, deposited, disbursed or withdrawn in connection with a transaction with an insured, including fees, transfers and disbursements from a trust account and all transactions concerning all interest bearing accounts;
- (h) Name of public adjuster who executed the contract;
- (i) Name of the attorney representing the insured, if applicable, and the name of the claims representatives of the insurance company; and
- (j) Evidence of financial responsibility in a format prescribed by the department.

(2) Records shall be maintained for at least five (5) years after the termination of the transaction with an insured and shall be open to examination by the department at all times.

(3) Records submitted to the department in accordance with this section that contain information identified in writing as proprietary by the public adjuster shall be treated as confidential by the department pursuant to [section 74-107, Idaho Code](#).

History.

I.C., § 41-5817, as added by 2008, ch. 179, § 1, p. 541; am. 2015, ch. 141, § 117, p. 379.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 141, substituted “74-107” for “9-340D” at the end of subsection (3).

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC’s central repository for the purpose of obtaining criminal background information.

§ 41-5818. Standards of conduct of public adjuster. — (1) A public adjuster is obligated, under his or her license, to serve with objectivity and complete loyalty the interest of his or her client alone; and to render to the insured such information, counsel and service, as within the knowledge, understanding and opinion in good faith of the licensee, as will best serve the insured's insurance claim needs and interests.

(2) A public adjuster shall not solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

(3) A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this chapter.

(4) A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission or other consideration established in the written contract with the insured, unless full written disclosure has been made to the insured as set forth in [section 41-5815\(6\), Idaho Code](#).

(5) A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer as set forth in [section 41-5815\(4\), Idaho Code](#).

(6) The public adjuster shall disclose to an insured if he or she has any interest or will be compensated by any construction firm, salvage firm, building appraisal firm, motor vehicle repair shop or any other firm that performs any work in conjunction with damages caused by the insured loss. The word "firm" shall include any person.

(7) Any compensation or anything of value in connection with an insured's specific loss that will be received by a public adjuster shall be disclosed by the public adjuster to the insured in writing, including the source and amount of any such compensation.

(8) Public adjusters shall adhere to the following general ethical requirements:

- (a) A public adjuster shall not undertake the adjustment of any claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the public adjuster's current expertise;
 - (b) A public adjuster shall not knowingly make any oral or written material misrepresentations or statements which are false or maliciously critical and intended to injure any person engaged in the business of insurance to any insured client or potential insured client;
 - (c) No public adjuster, while so licensed by the department, may represent or act as a company adjuster or as an independent adjuster on the same claim;
 - (d) The contract shall not be construed to prevent an insured from pursuing any civil remedy after the three (3) business day revocation or cancellation period;
 - (e) A public adjuster shall not enter into a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the persons who shall perform repair work; and
 - (f) A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.
- (9) A public adjuster may not agree to any loss settlement without the insured's knowledge and consent.

History.

I.C., § 41-5818, as added by 2008, ch. 179, § 1, p. 542.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5819. Reporting of actions. — (1) The public adjuster shall report to the department any administrative action taken against the public adjuster in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

(2) Within thirty (30) days of the initial pretrial hearing date, the public adjuster shall report to the department any criminal prosecution of the public adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

History.

I.C., § 41-5819, as added by 2008, ch. 179, § 1, p. 543.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5820. Rules. — The department may, in accordance with [section 41-211, Idaho Code](#), promulgate reasonable rules as are necessary or proper to carry out the purposes of this chapter.

History.

[I.C., § 41-5820](#), as added by 2008, ch. 179, § 1, p. 543.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of [section 41-5805, Idaho Code](#), do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

§ 41-5821. Severability. — If any provisions of this chapter, or the application of a provision to any persons or circumstances, shall be held invalid, the remainder of the chapter, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

History.

I.C., § 41-5821, as added by 2008, ch. 179, § 1, p. 543.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2008, ch. 179 provided that the act should take effect on and after July 1, 2008. Provided however, that the provisions of **section 41-5805, Idaho Code**, do not become effective until a state participates in the NAIC's central repository for the purpose of obtaining criminal background information.

Chapter 59

IDAHO HEALTH CARRIER EXTERNAL REVIEW ACT

Sec.

41-5901. Short title.

41-5902. Purpose and intent.

41-5903. Definitions.

41-5904. Applicability and scope.

41-5905. Notice of right to external review.

41-5906. Request for external review.

41-5907. Exhaustion of internal grievance process.

41-5908. Standard external review.

41-5909. Expedited external review.

41-5910. Binding nature of external review decision.

41-5911. Approval of independent review organizations.

41-5912. Minimum qualifications for independent review organizations.

41-5913. Hold harmless for independent review organizations.

41-5914. External review reporting requirements.

41-5915. Funding of external review.

41-5916. Disclosure requirements.

41-5917. Severability.

§ 41-5901. Short title. — This chapter shall be known and may be cited as the “Idaho Health Carrier External Review Act.”

History.

I.C., § 41-5901, as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5902. Purpose and intent. — The purpose of this chapter is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of a final adverse benefit determination, as defined in this chapter.

History.

I.C., § 41-5902, as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5903. Definitions. — For purposes of this chapter:

(1) “Administrative record” means all nonprivileged documents, records or other health information which was submitted, considered, generated or relied upon by the health carrier in the course of making the adverse benefit determination, including, but not limited to, documents, records or other information that constitutes the plan’s policy statements or guidance concerning the denied treatment or benefit, all records provided by the covered person or the covered person’s medical care provider related to the denied treatment or benefit, all records provided to an independent review organization as part of the independent review of the denied treatment or benefit and the opinion issued by the independent review organization.

(2) “Adverse benefit determination” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or has been determined to be an investigational service, and the requested service or payment for the service is therefore terminated, denied or reduced.

(3) “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.

(4) “Authorized representative” means:

(a) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person or the covered person’s treating health care professional only when the covered person is unable to provide consent.

(5) “Best evidence” means evidence based on randomized clinical trials.

(a) If randomized clinical trials are not available, then cohort studies or case-control studies;

(b) If studies in paragraph (a) of this subsection (5) are not available, then case-series.

(6) “Case-control study” means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

(7) “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(8) “Case-series” means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(9) “Certification” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(10) “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(11) “Cohort study” means a prospective evaluation of two (2) groups of patients with only one (1) group of patients receiving a specific intervention(s).

(12) “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment.

(13) “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms and conditions of a health benefit plan.

(14) “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan. A covered person includes the authorized representative of the covered person.

(15) “Director” means the director of the Idaho department of insurance.

(16) “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(17) “Disclose” means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(18) “Evidence-based standard” means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(19) “Expedited external review” is the procedure available for urgent care requests for external review.

(20) “Expert” means a specialist with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

(21) “Facility” means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

(22) “Final adverse benefit determination” means an adverse benefit determination, as defined in [section 41-5903\(2\), Idaho Code](#), involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier’s internal grievance process procedures as set forth in the covered person’s health benefit plan.

(23) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(24) “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(25) “Health care provider” or “provider” means a health care professional or a facility.

(26) “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

(27) “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a disability insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

(28) “Health information” means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

- (a) The past, present or future physical, mental or behavioral health or condition of an individual or a member of the individual’s family;
- (b) The provision of health care services to an individual; or
- (c) Payment for the provision of health care services to an individual.

(29) “Independent review organization” means an entity that conducts independent external reviews of final adverse benefit determinations.

(30) “Investigational” means the definition provided in the covered person’s health benefit plan; if the health benefit plan does not provide a definition of “investigational,” it shall be defined as follows: Any treatment, procedure, facility, equipment, drug, device or commodity, regardless of its medical necessity, which is experimental, or in the early developmental stage of medical technology, for which there are no randomized clinical trials or, absent such trials, for which there are no cohort studies or case-control studies or, absent such studies, then for which there is no case-series. The determination by the health carrier will be based on objective data and information obtained by the health carrier and reviewed, by competent medical personnel, according to the following:

- (a) The technology has final approval from the appropriate government regulatory bodies;

(b) Medical or scientific evidence regarding the technology is sufficiently comprehensive to permit well substantiated conclusions concerning the safety and effectiveness of the technology;

(c) The technology's overall beneficial effects on health outweigh the overall harmful effects on health; and

(d) The technology is as beneficial as any established alternative.

When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy the criteria of paragraphs (c) and (d) of this subsection (30).

(31) "Medically necessary" or "medical necessity" means the definition provided in the covered person's health benefit plan; if the covered person's health benefit plan does not define "medically necessary" or "medical necessity," these terms shall mean health care services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a covered person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease;

(c) Not primarily for the convenience of the covered person, physician or other health care provider; and

(d) Not more costly than an alternative service or sequence of services or supply, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered person's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible medical or scientific evidence.

(32) "Medical or scientific evidence" means evidence found in the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus (MEDLINE) and elsevier science ltd. for indexing in excerpta medicus [medica] (EMBASE);

(c) Medical journals recognized by the U.S. secretary of health and human services under section 1861(t)(2) of the federal social security act;

(d) The following standard reference compendia:

(i) The American hospital formulary service — drug information;

(ii) Drug facts and comparisons;

(iii) The United States pharmacopoeia — drug information; and

(iv) The American dental association accepted dental therapeutics.

(e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(i) The federal agency for healthcare research and quality;

(ii) The national institutes of health;

(iii) The national cancer institute;

(iv) The national academy of sciences;

(v) The centers for medicare and medicaid services;

(vi) The federal food and drug administration; and

(vii) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services;
or

(f) Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (a) through (e) of this subsection (32).

(33) “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(34) “Post service review” means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

(35) “Pre-service review” means utilization review conducted prior to an admission or a course of treatment.

(36) “Protected health information” means health information:

(a) That identifies an individual who is the subject of the information; or

(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(37) “Randomized clinical trial” means a controlled, prospective study of patients who have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(38) “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(39) “Urgent care request” means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

- (a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
- (b) In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
- (c) The treatment would be significantly less effective if not promptly initiated.

The opinion of the covered person's treating health care professional with knowledge of the covered person's medical condition that a request is an urgent care request should be treated with deference.

(40) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, pre-service review, second opinion, certification, concurrent review, case management, discharge planning or post service review.

(41) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

History.

I.C., § 41-5903, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 1, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, inserted "appropriateness, health care setting, level of care, effectiveness" near the end of subsection (2) and inserted "a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or" in the introductory paragraph in subsection (39).

Federal References.

Section 1861(t)(2) of the federal social security act, referred to in paragraph (32)(c), is compiled as [42 USCS § 1395x\(t\)\(2\)](#)

Compiler's Notes.

The bracketed insertion in paragraph (32)(b) was added by the compiler to correct the name of the referenced publication.

For list of journals indexed for national institutes of health's national library of medicine (MEDLINE), referred to in paragraph (32)(b), see <https://www.nlm.nih.gov/pubs/factsheets/medline.html>.

For Elsevier's Embase, referred to in paragraph (32)(b), see <https://www.elsevier.com/solutions/embase-biomedical-research>.

For drug information from the American hospital formulary service, referred to in paragraph (32)(d), see <http://www.ahfsdruginformation.com>.

For United States pharmacopoeia, referred to in paragraph (32)(d), see <http://www.usp.org>.

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: "This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010."

§ 41-5904. Applicability and scope. — (1) Except as provided in subsection (2) of this section, this chapter shall apply to all health carriers.

(2) The provisions of this chapter shall not apply to a plan, policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage; nor shall this chapter apply to a credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, limited benefit health plans or any other limited supplemental benefit; nor shall this chapter apply to a medicare advantage plan or medicare supplemental policy of insurance, as defined by the director by rule, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issued under chapter 55, title 10, of the United States Code and any coverage issued as supplemental to that coverage; nor shall this chapter apply to any coverage issued as supplemental to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis; nor shall this chapter apply to a single employer self-funded employee benefit plan subject to and operated in compliance with the employee retirement income security act of 1974 (ERISA); provided however, the single employer self-funded ERISA employee benefit plan administrator or designee may, by timely and appropriate written notice to the director, voluntarily elect to comply with the provisions of this chapter either for a single plan beneficiary or for a specific period of time. The director may promulgate rules establishing the procedure for an employee benefit plan administrator or designee, to voluntarily comply with the provisions of this chapter and to provide for an administrative fee to be paid by the employee benefit plan administrator for each voluntary external review request submitted to the department pursuant to this chapter.

(3) The availability or use of external review pursuant to this chapter shall not alter the standard of review used by a court of competent jurisdiction when adjudicating the health carrier's final adverse benefit determination.

History.

I.C., § 41-5904, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 2, p. 333; am. 2011, ch. 258, § 1, p. 703.

STATUTORY NOTES**Amendments.**

This section was amended by two 2011 acts which appear to be compatible and have been compiled together.

The 2011 amendment, by ch. 122, deleted “final adverse benefit determinations which involve an issue of medical necessity or investigational service or supply” from the end of subsection (1).

The 2011 amendment, by ch. 258, deleted “final adverse benefit determinations which involve an issue of medical necessity or investigational service or supply” from the end of subsection (1); and, in subsection (2), added the proviso at the end of the first sentence and added the last sentence.

Federal References.

Chapter 55 of title 10 of the United States Code, referred to in subsection (2), is codified as [10 USCS § 1071 et seq.](#)

The employee retirement income security act of 1974, referred to in subsection (2), is codified as [29 USCS § 1001 et seq.](#)

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5905. Notice of right to external review. — (1) When a final adverse benefit determination is made, the health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, and include the appropriate statements and information set forth in subsection (2) of this section at the same time the health carrier sends written notice of the final adverse benefit determination.

(2) The director may prescribe by rule the form and content of the notice required under this section, which shall include:

(a) The following, or substantially equivalent, language:

“We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of your health care service or supply, or your health care service or supply was denied based upon a determination that it was investigational. You may request an external review by submitting a written request to the department of insurance.”

The notice shall include contact information for the department of insurance, including the website, address and telephone number.

(b) If the adverse benefit determination is for a pre-service or concurrent service, the health carrier shall notify the covered person of the right to an expedited external review if the request is an urgent care request. The notification shall include the definition of urgent care request.

(c) The health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to [section 41-5916, Idaho Code](#), highlighting the provisions in the external review procedures that give the covered person the opportunity to submit additional information, and include any forms used to process an external review.

(d) The health carrier shall include an authorization form, or other document approved by the director, that complies with the requirements of [45 CFR section 164.508](#), by which the covered person, for purposes of conducting an external review pursuant to this chapter, authorizes the health carrier and the covered person's treating health care providers to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review. Until the director receives this form from the covered person, duly executed, the external review process is stayed and the health carrier has no obligations under this chapter.

History.

[I.C., § 41-5905](#), as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 3, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, substituted “When a final adverse benefit determination is made” for “If at the conclusion of the health carrier’s internal grievance process the decision is adverse to the covered person, based upon a determination that the service or supply to be provided or which was provided did not meet medical necessity criteria or is investigational” at the beginning of subsection (1); in paragraph (2)(a), inserted “appropriateness, health care setting, level of care or effectiveness”; and, in subsection (2)(b), deleted “and was denied based upon a failure to meet medical necessity criteria or because the service was determined to be investigational” following “concurrent service.”

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5906. Request for external review. — A covered person may make a request for an external review of a final adverse benefit determination. Except for a request for an expedited external review as set forth in [section 41-5909, Idaho Code](#), all requests for external review shall be made in writing to the director. The director may prescribe by rule the form and content of external review requests required to be submitted under this section.

History.

[I.C., § 41-5906](#), as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 4, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, substituted “for” for “to” in the section heading and deleted the former last sentence, which read: “The director shall prescribe by rule the amount of the administrative filing fee, if any, to be paid by the covered person when the external review request is submitted.”

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5907. Exhaustion of internal grievance process. — (1) Except as provided in subsection (2) of this section, a request for an external review pursuant to section 41-5908, 41-5909 or 41-5910, Idaho Code, shall not be made until the covered person has exhausted the health carrier's internal grievance process. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person:

(a) Has filed and completed a grievance, involving an adverse benefit determination, according to the terms and conditions of the covered person's health benefit plan; or

(b) Except to the extent the covered person requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty-five (35) days following the date the covered person filed the grievance with the health carrier, or the covered person filed a grievance on an urgent care request on a pre-service or concurrent care adverse benefit determination and has not received a determination from the health carrier within three (3) business days after filing.

(2) A request for an external review of an adverse benefit determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in the health carrier's grievance appeal process whenever:

(a) The health carrier agrees to waive the exhaustion requirement;

(b) The health carrier has failed to strictly follow its duties in affording a timely, full and fair opportunity for the covered person to take advantage of the internal grievance procedures; or

(c) The urgent care request involves a medical condition for which the time frame for completion of the carrier's internal grievance process pursuant to this section would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and the covered person has applied for expedited external review at the same time as applying for an expedited internal review.

History.

I.C., § 41-5907, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 5, p. 333.

STATUTORY NOTES**Amendments.**

The 2011 amendment, by ch. 122, added present paragraphs (2)(b) and (2)(c), and made related redesignations; and deleted former subsection (2), which read: “If the requirement to exhaust the health carrier’s internal grievance procedures is waived under subsection (1)(b) of this section, the covered person may file a request in writing for a standard external review, or where appropriate, an expedited external review.”

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5908. Standard external review. — (1) Within four (4) months after the date of issuance of a notice of a final adverse benefit determination pursuant to [section 41-5905, Idaho Code](#), a covered person may file a request for an external review with the director. The request shall be made on such form as may be designated by the director.

(2) Within seven (7) days after the date of receipt of a request for external review pursuant to subsection (1) of this section, the director shall send a copy of the request to the health carrier.

(3) Within fourteen (14) days following the date of receipt of the copy of the external review request from the director pursuant to subsection (2) of this section, the health carrier shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a post service review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) The health care service that is the subject of the final adverse benefit determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or the service or supply is investigational;

(c) The covered person has exhausted the health carrier's internal grievance process as set forth in the covered person's health benefit plan, unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to [section 41-5907, Idaho Code](#); and

(d) The covered person has provided all the information and forms required to process an external review, including the release form provided under [section 41-5905\(2\)\(d\), Idaho Code](#).

(4) Within five (5) business days after completion of the preliminary review, the health carrier shall notify the director and covered person in

writing whether the request is complete and whether the request is eligible for external review.

(5) If the request is not complete, the health carrier shall inform the covered person and the director in writing and include in the notice what information or materials are needed to make the request complete.

(6) If the request is not eligible for external review, the health carrier shall inform the covered person and the director in writing and include in the notice the reasons for its ineligibility.

(7) The director may prescribe by rule the form for the health carrier's notice of initial determination under this section and any supporting information to be included in the notice. The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that the external review request is ineligible for review, may be appealed to the director.

(8) The director may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review. The director's decision shall be made in accordance with the applicable procedural requirements of this chapter and the terms and conditions of the covered person's health benefit plan.

(9) Whenever the director receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (3) of this section, within seven (7) days after the date of receipt of the notice, the director shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to [section 41-5911, Idaho Code](#), to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(b) Notify, in writing, the covered person of the request's eligibility and acceptance for external review.

(c) The director shall include in the notice provided to the covered person a statement that the covered person may submit, in writing, to the assigned independent review organization within seven (7) days

following the date of receipt of the notice provided pursuant to subsection (9)(b) of this section, additional information that the independent review organization shall consider when conducting the external review.

(10) In reaching a decision, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(11) Within fourteen (14) days after the date of receipt of the notice provided pursuant to subsection (9)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination or final adverse benefit determination.

(12) Except as provided in subsection (13) of this section, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subsection (11) of this section, shall not delay the conduct of the external review.

(13) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subsection (11) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse benefit determination or final adverse benefit determination.

(14) Within one (1) business day after making the decision to terminate the external review pursuant to subsection (13) of this section, the independent review organization shall notify the covered person, the health carrier and the director.

(15) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (11) of this section, and any other information submitted in writing to the independent review organization by the covered person pursuant to subsection (9)(c) of this section; provided however, that if the covered person does submit new information in writing to the independent review organization pursuant to

subsection (9)(c) of this section, then the health carrier is entitled to seven (7) days following its receipt thereof to submit additional responsive information to the internal review organization.

(16) Upon receipt of any information submitted by the covered person pursuant to subsection (9)(c) of this section, the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

(17) Upon receipt of the information, if any, required to be forwarded pursuant to subsection (16) of this section, the health carrier may reconsider its adverse determination or final adverse benefit determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review. The assigned independent review organization shall review all of the information and documents received pursuant to subsection (15) of this section.

(18) The external review may be terminated if the health carrier decides to reverse its final adverse benefit determination and provide coverage or payment for the health care service that is the subject of the final adverse benefit determination. Within two (2) business days after making the decision to reverse its final adverse benefit determination, the health carrier shall notify the covered person, the assigned independent review organization and the director in writing of its decision.

(19) In addition to the documents and information provided pursuant to subsection (11) of this section, the assigned independent review organization, to the extent the information or documents are available, shall consider the following in reaching a decision:

- (a) The covered person's medical records;
- (b) The attending health care professional's recommendation;
- (c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's treating provider;
- (d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions

of coverage under the covered person's health benefit plan with the health carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;

(e) The most appropriate practice guidelines, which shall include the applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations, health carrier's internal guidelines and medical policies;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization;

(g) Medical or scientific evidence, as defined in [section 41-5903\(32\), Idaho Code](#);

(h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (19) to the extent the information or documents are available.

(20) Within forty-two (42) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the final adverse benefit determination to the covered person, the health carrier and the director. The independent review organization shall include in the notice:

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization received the assignment from the director to conduct the external review;

(c) The date the external review was conducted;

(d) The date of its decision;

(e) The principal reason or reasons for its decision, including an explanation of the scientific or clinical judgment applied to reach its decision;

(f) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision; and

(g) References to the terms and conditions of the health benefit plan at issue, including an explanation of how its decision is consistent with them.

(21) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the final adverse benefit determination and other circumstances, including conflict of interest concerns pursuant to [section 41-5912, Idaho Code](#).

(22) Upon receipt of a notice of a decision pursuant to subsection (20) of this section reversing the adverse benefit determination or final adverse benefit determination, the health carrier shall approve as soon as reasonably practicable but not later than one (1) business day after receipt of the notice the coverage that was the subject of the adverse benefit determination or final adverse benefit determination.

History.

[I.C., § 41-5908](#), as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 6, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, inserted “appropriateness, health care setting, level of care, effectiveness” in subsection (3)(b); substituted the last occurrence of “independent” for “internal” in subsection (15); and added subsection (22).

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5909. Expedited external review. — (1) A covered person may make a request for an expedited external review of a pre-service or concurrent service adverse benefit determination where the requested service meets the definition of an urgent care request and the covered person has exhausted the health carrier's internal grievance process or is entitled to request external review before exhausting the health carrier's internal grievance process as provided in [section 41-5907, Idaho Code](#).

(2) Upon receipt of a request for an expedited external review, the director shall send a copy of the request to the health carrier.

(3) Upon receipt of the request pursuant to subsection (2) of this section, the health carrier shall determine, as soon as possible but not later than the second full business day thereafter, whether the carrier agrees that the request meets the reviewability requirements set forth in [section 41-5908\(3\), Idaho Code](#). The health carrier shall notify the director and the covered person of its eligibility determination as soon as reasonably practicable but not later than one (1) business day after making the determination.

(a) The director may prescribe by rule the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(b) The notice of initial determination shall include a statement informing the covered person that a health carrier's initial determination that an external review request is ineligible for review, may be appealed to the director.

(4) The director may determine that a request is eligible for external review pursuant to [section 41-5908\(3\), Idaho Code](#), notwithstanding a health carrier's initial determination that the request is ineligible, and require that it be referred for external review. In making a determination under this subsection (4), the director's decision shall be made in accordance with the applicable procedural requirements of this chapter and the terms and conditions of the covered person's health benefit plan.

(5) Upon receipt of the notice that the request meets the reviewability requirements, the director shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the director pursuant to [section 41-5911, Idaho Code](#). The director shall notify the health carrier and the covered person of the name of the assigned independent review organization.

(6) In reaching a decision in accordance with subsection (9) of this section, the assigned independent review organization is not bound by the exercise of discretion or any decisions or conclusions reached during the health carrier's internal grievance process.

(7) Upon receipt of the notice from the director of the name of the independent review organization assigned to conduct the expedited external review pursuant to subsection (5) of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse benefit determination and the final adverse benefit determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(8) In addition to the documents and information provided or transmitted pursuant to subsection (7) of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

- (a) The covered person's pertinent medical records;
- (b) The attending health care professional's recommendation;
- (c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person or the covered person's treating provider;
- (d) The terms and conditions of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is controlled by the terms and conditions of coverage under the covered person's health benefit plan with the health

carrier to the extent the health plan's terms and conditions are not in conflict with this chapter;

(e) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations, the health carrier's internal guidelines and medical policies;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designated utilization review organization in making the adverse benefit determination;

(g) Medical or scientific evidence, as defined in [section 41-5903\(32\), Idaho Code](#);

(h) The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (a) through (g) of this subsection (8) to the extent the information and documents are available.

(9) As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in [section 41-5908\(3\), Idaho Code](#), the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the final adverse benefit determination; and

(b) Notify the covered person, the health carrier and the director of the decision.

(10) If the notice provided pursuant to subsection (9)(b) of this section was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, the health carrier and the director, which shall include an explanation of the scientific or clinical judgment for the determination; and

(b) Include the information set forth in [section 41-5908\(20\), Idaho Code](#).

(11) Upon receipt of the notice of a decision pursuant to subsection (10) of this section reversing the final adverse benefit determination, the health carrier shall notify the director and the covered person of its intent to pay the covered benefit as soon as reasonably practicable but not later than one (1) business day after receiving the notice of decision.

(12) An expedited external review shall not be provided for post service final adverse benefit determinations.

(13) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the final adverse benefit determination and other circumstances, including conflict of interest concerns pursuant to [section 41-5912, Idaho Code](#).

History.

[I.C., § 41-5909](#), as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 7, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, in subsection (1), deleted “After having exhausted the health carrier’s internal grievance process as provided in [section 41-5907, Idaho Code](#)” from the beginning, deleted “based on medical necessity or investigational” following “determination,” and added “and the covered person has exhausted the health carrier’s internal grievance process or is entitled to request external review before exhausting the health carrier’s internal grievance process as provided in [section 41-5907, Idaho Code](#)”; in paragraph (10)(a), deleted “addressing the medical necessity criteria as defined in this chapter or, where the appeal is based upon a denial of a service as investigational, addressing the criteria for determination of investigational status as defined in this chapter” from the end; and, in subsection (11), substituted “its intent to pay the covered benefit” for “its eligibility determination” and substituted “after receiving the notice of decision” for “after making the determination.”

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5910. Binding nature of external review decision. — (1) For a health care benefit plan not subject to the employee retirement income security act of 1974 (ERISA), the external review decision is final and binding on the health carrier and on the covered person. No judicial action or proceeding arising out of the external review decision or the issues determined by the external review decision shall be permitted. For a health care benefit plan subject to ERISA, the external review decision is final and binding on the health carrier; however, should the covered person seek judicial review of the external review decision, then the external review record and decision shall be included as a part of the administrative record for the purpose of review by any court of competent jurisdiction.

(2) A covered person may not file a subsequent request for external review involving the same adverse benefit determination or final adverse benefit determination for which the covered person has already received an external review decision pursuant to this chapter.

History.

I.C., § 41-5910, as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Federal References.

The employee retirement income security act of 1974 (ERISA), referred to in subsection (1), is compiled as [29 USCS § 1001 et seq.](#)

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5911. Approval of independent review organizations. — (1) The director shall approve independent review organizations eligible to be assigned on a random basis to conduct external reviews under this chapter.

(2) In order to be eligible for approval by the director under this section to conduct external reviews under this chapter an independent review organization shall:

(a) Except as otherwise provided in this section, be accredited by a nationally recognized private accrediting entity that the director has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under [section 41-5912, Idaho Code](#); and

(b) Submit an application for approval in accordance with subsection (4) of this section.

(3) The director shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(4) Any independent review organization wishing to be approved to conduct external reviews under this chapter shall submit the application form and include with the form all documentation and information necessary for the director to determine whether the independent review organization satisfies the minimum qualifications established under [section 41-5912, Idaho Code](#).

(5) The director shall publish prominently on the department of insurance website notice of a submitted application or reapplication by an independent review organization to provide external reviews under this chapter.

(a) Any person wishing to comment on an application shall have forty-two (42) days, from the publication of notice by the director, to provide written comments to the director on the application or reapplication submitted by an independent review organization.

(b) The director shall review and consider the written comments received in determining whether to approve the application or reapplication of an independent review organization.

(c) The director may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(6) The director may charge an application fee that independent review organizations shall submit to the director with an application for approval and reapproval.

(7) An approval is effective for two (2) years, unless the director determines before its expiration that the independent review organization no longer satisfies the minimum qualifications established under [section 41-5912, Idaho Code](#).

(8) The director shall maintain and periodically update a list of approved independent review organizations. Whenever the director determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under [section 41-5912, Idaho Code](#), the director shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this chapter. The director may also establish a standard flat fee schedule for each external review performed by the independent review organization.

(9) The director may promulgate administrative rules to carry out the provisions of this section.

History.

[I.C., § 41-5911](#), as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January

1, 2010.”

§ 41-5912. Minimum qualifications for independent review organizations. — (1) To be approved to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter that include, at a minimum:

- (a) A quality assurance mechanism in place that:
 - (i) Ensures that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner;
 - (ii) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;
 - (iii) Ensures the confidentiality of medical and treatment records and clinical review criteria; and
 - (iv) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this chapter;
 - (b) A toll free telephone service to receive information on a twenty-four (24) hour day, seven (7) day a week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and
 - (c) An agreement to maintain and provide to the director the information set out in [section 41-5914, Idaho Code](#).
- (2) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:
- (a) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(b) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(c) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(d) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

(3) In addition to the requirements set forth in subsection (1) of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.

(4) In addition to any other requirements, to be approved to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review, nor any clinical reviewer assigned by the independent organization to conduct the external review, may have a material professional, familial or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review;

(b) The covered person whose treatment is the subject of the external review;

(c) Any officer, director or management employee of the health carrier that is the subject of the external review;

(d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(e) The facility at which the recommended health care service or treatment would be provided; or

(f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(5) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of subsection (4) of this section, the director shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case, or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case, may have an apparent professional, familial or financial relationship or connection with a person described in subsection (4) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(6) An independent review organization that is accredited by a nationally recognized private accrediting entity, which has independent review accreditation standards that the director has determined are equivalent to or exceed the minimum qualifications of this section, shall be presumed in compliance with this section to be eligible for approval under [section 41-5911, Idaho Code](#).

(7) The director shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section.

(8) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the director in order for the director to determine whether the entity's standards are equivalent to or exceed the minimum qualifications established under this section.

(9) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

(10) Each independent review organization applying to the director to be approved shall include in its application its schedule of costs and fees for performing external reviews and shall file with the director any subsequent changes to its fee schedule. If the director finds that the proposed fees are excessive or unreasonable, the director shall disapprove the application or, if the review organization has already been approved, remove the organization from the list of eligible review organizations. An independent review organization may not impose charges for a review under this chapter that exceed those set forth on its schedule of fees filed with the director.

History.

I.C., § 41-5912, as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5913. Hold harmless for independent review organizations. —
No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages or otherwise to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence; provided that the health carrier shall not be liable in damages or otherwise to any person for any opinions rendered or acts or omissions performed by the independent review organization, its employees, agents or contractors within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter.

History.

I.C., § 41-5913, as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: "This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010."

§ 41-5914. External review reporting requirements. — (1) An independent review organization assigned pursuant to this chapter to conduct an external review shall maintain written records in the aggregate for Idaho by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the director, as required under this section. Each independent review organization required to maintain written records on all requests for external review pursuant to this section for which it was assigned to conduct an external review shall submit to the director, upon request or at specified intervals, a report in the format specified by the director.

(2) The report shall include in the aggregate for Idaho for each health carrier:

- (a) The total number of requests for external review;
- (b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the final adverse benefit determinations and the number resolved reversing the final adverse benefit determinations;
- (c) The average length of time for resolution;
- (d) A summary of the types of coverages or cases for which an external review was sought;
- (e) The number of external reviews pursuant to [section 41-5908\(18\), Idaho Code](#), that were terminated as the result of a reconsideration by the health carrier of its final adverse benefit determination after the receipt of additional information from the covered person; and
- (f) Any other information the director may reasonably request or require.

(3) The independent review organization shall retain the written records required pursuant to this section for at least five (5) years.

(4) Each health carrier shall maintain written records in the aggregate for Idaho for each type of health benefit plan offered by the health carrier on all

requests for external review that the health carrier receives notice of from the director pursuant to this chapter.

(5) Each health carrier is required to maintain written records on all requests for external review pursuant to subsection (1) of this section and shall submit to the director, upon request or at specified intervals, a report in the format specified by the director. The report shall include in the aggregate for Idaho and by type of health benefit plan:

- (a) The total number of requests for external review;
- (b) From the total number of requests for external review reported, the number of requests determined eligible for a full external review; and
- (c) Any other information the director may reasonably request or require.

(6) The health carrier shall retain the written records required pursuant to this section for at least five (5) years.

History.

I.C., § 41-5914, as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5915. Funding of external review. — The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the reasonable cost of the independent review organization for conducting the external review.

History.

I.C., § 41-5915, as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 8, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, deleted the former last sentence, which read: “The director may provide by rule for an administrative fee to offset the department’s costs associated with external review to be paid by the covered person at the time he makes a request for external review.”

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5916. Disclosure requirements. — (1) Each health carrier shall include a summary description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons. The disclosure shall be in a format prescribed by the director.

(2) The description required under subsection (1) of this section shall include:

(a) A statement that informs the covered person of the right of the covered person to file a request for an external review of a final adverse benefit determination with the director;

(b) An explanation that external review and, in certain circumstances, expedited external review are available when the final adverse benefit determination involves an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or investigational service or supply;

(c) The website, telephone number and address of the director; and

(d) A statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review including any judicial review of the external review decision pursuant to ERISA, if applicable.

(e) If the health plan is not subject to ERISA, a statement informing the covered person that the plan is not subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on both the covered person and the health carrier, as provided in [section 41-5910, Idaho Code](#). If the health plan is subject to ERISA, the statement shall inform the covered person that the plan is subject to ERISA and that if the covered person elects to request external review, the external review decision of the independent review organization shall be final and binding on the health carrier but not the covered person, as

provided in [section 41-5910, Idaho Code](#), and that the covered person may have the right to judicial review under ERISA in a court of competent jurisdiction.

History.

[I.C., § 41-5916](#), as added by 2009, ch. 87, § 1, p. 240; am. 2011, ch. 122, § 9, p. 333.

STATUTORY NOTES

Amendments.

The 2011 amendment, by ch. 122, inserted “appropriateness, health care setting, level of care, effectiveness” in paragraph (2)(b).

Federal References.

ERISA, the employee retirement income security act of 1974, referred to in this section, is codified as [29 USCS § 1001 et seq.](#)

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

§ 41-5917. Severability. — The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

History.

I.C., § 41-5917, as added by 2009, ch. 87, § 1, p. 240.

STATUTORY NOTES

Compiler's Notes.

The term “this act” refers to S.L. 2009, Chapter 87, which is codified as §§ 41-5901 to 41-5917.

Effective Dates.

Section 2 of S.L. 2009, ch. 87 provided: “This chapter shall be in full force and effect for all covered plans issued or renewed on or after January 1, 2010.”

Chapter 60

IMMUNIZATION ASSESSMENTS

Sec.

41-6001. Legislative intent. [Null and void, effective July 1, 2024.]

41-6002. Definitions. [Null and void, effective July 1, 2024.]

41-6003. Idaho immunization assessment board. [Null and void, effective July 1, 2024.]

41-6004. Plan of operation. [Null and void, effective July 1, 2024.]

41-6005. Power and liability of the board. [Null and void, effective July 1, 2024.]

41-6006. Assessments. [Null and void, effective July 1, 2024.]

41-6007. Idaho immunization dedicated vaccine fund. [Null and void, effective July 1, 2024.]

41-6008. Rulemaking authority. [Null and void, effective July 1, 2024.]

§ 41-6001. Legislative intent. [Null and void, effective July 1, 2024.]

— The intent of the legislature is to provide a supplemental funding mechanism for the Idaho immunization program administered by the Idaho department of health and welfare, by creating a dedicated vaccine fund and an independent board, which board is empowered to assess fees from all carriers. The chapter's goal is to ensure access to childhood vaccinations in Idaho, by decreasing costs and enabling the maintenance of a single distribution of vaccines available to health care providers in Idaho who administer the vaccines to program eligible children.

History.

I.C., § 41-6001, as added by 2010, ch. 32, § 1, p. 60.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Compiler's Notes.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024."

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-6002. Definitions. [Null and void, effective July 1, 2024.] — As used in this chapter:

(1) “Board” means the Idaho immunization assessment board created by [section 41-6003, Idaho Code](#).

(2) “Carrier” means: any entity subject to regulation by the department that provides or is authorized to provide health insurance or health benefit plans, or that administers health insurance or health benefit coverage or that otherwise provides a plan of health insurance or health benefits; or a foreign insurer who provides health insurance coverage or benefits to residents of this state as certificate holders under a group policy issued or delivered outside of this state. For purposes of this chapter, the term “carrier” includes an insurance company, a hospital or professional service corporation, a fraternal benefit society, a managed care organization, entities that provide excess or stop-loss insurance, and persons or entities required to be registered with the director under chapter 9, title 41, Idaho Code. For the purposes of this chapter, the term “carrier” does not include an entity that only issues policies, certificates or subscriber contracts within the state of Idaho that are limited to a specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker’s compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

(3) “Director” means the director of the department of insurance of the state of Idaho.

(4) “Fund” means the Idaho immunization dedicated vaccine fund created in [section 41-6007, Idaho Code](#).

(5) “Idaho immunization program” means that program administered by the Idaho department of health and welfare to provide vaccinations against diseases to Idaho children consistent with Idaho and federal law.

(6) “Plan of operation” means the plan of operation of the fund as established by the board.

(7) “Program-eligible child” means any child, natural or adopted, who is under nineteen (19) years of age, whose custodial parent or legal guardian resides in Idaho and who is not eligible for the federal vaccines for children program.

(8) “Vaccine” means any preparations of killed microorganisms, living attenuated organisms or living fully virulent organisms that are approved by the federal food and drug administration and recommended by the federal advisory committee on immunization practices of the centers for disease control and prevention.

(9) “Vaccines for children” program is that federally funded program that provides vaccines at no cost to eligible children pursuant to section 1928 of the social security act.

History.

I.C., § 41-6002, as added by 2010, ch. 32, § 1, p. 60; am. 2010, ch. 187, § 1, p. 399.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Amendments.

The 2010 amendment, by ch. 187, in subsection (2), in the first sentence, substituted “any entity subject to regulation by the department” for “any entity required to be licensed or registered in the state of Idaho,” deleted “health insurance, health benefit plans” following “that provides,” inserted “or health benefit plans,” and added the language beginning “or that otherwise provides a plan of health insurance” through to the end, and in the second sentence, deleted “acting as an administrator or third party administrator of health insurance or health benefits as defined by or” following “and persons or entities,” and inserted “chapter 9.”

Federal References.

Section 1928 of the social security act, referred to in subsection (9), is codified as [42 USCS § 1396s](#).

Compiler's Notes.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024."

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

Section 2 of S.L. 2010, ch. 187 declared an emergency retroactively to February 1, 2010 and approved March 31, 2010.

§ 41-6003. Idaho immunization assessment board. [Null and void, effective July 1, 2024.] — (1) There is hereby created in the Idaho department of insurance the Idaho immunization assessment board. The board will perform an essential governmental function in the exercise of powers conferred upon it by this chapter and shall be a governmental entity within the meaning of chapter 9, title 6, Idaho Code.

(2) The board shall consist of ten (10) members and one (1) ex officio member:

(a) Seven (7) members shall be appointed by the director and serve at the pleasure of the director. In selecting the members of the board, the director shall appoint:

(i) Three (3) members representing carriers, one (1) of whom shall represent administrators or third-party administrators;

(ii) One (1) primary care physician licensed and practicing in Idaho; and

(iii) Three (3) members representing the Idaho business community, one (1) of whom shall represent a private self-funded insurance plan;

(b) One (1) member appointed by the director of the department of health and welfare;

(c) One (1) member shall be a member of the senate, appointed by the president pro tempore of the senate;

(d) One (1) member shall be a member of the house of representatives, appointed by the speaker of the house of representatives; and

(e) The director or the director's designated representative shall serve as an ex officio eleventh member of the board.

(3) The initial board members appointed by the director pursuant to subsection (2)(a) of this section shall be appointed as follows: Legislative members of the board shall serve for a term of two (2) years.

(a) Two (2) members, as determined by the director, shall serve an initial term of two (2) years;

(b) Two (2) members, as determined by the director, shall serve an initial term of three (3) years; and

(c) One (1) member, as determined by the director, shall serve an initial term of four (4) years.

Subsequent board members appointed by the director pursuant to subsection (2)(a) of this section shall serve for terms of three (3) years.

(4) A vacancy on the board appointed by the director pursuant to subsection (2)(a) of this section shall be filled by the director. A vacancy in a legislative member's position on the board shall be filled in the same manner as the original appointment.

(5) Except for employees of the state of Idaho, members of the board shall not receive compensation or reimbursement for expenses for their service on the board. Employees of the state of Idaho serving on the board shall be reimbursed for their vouched expenses associated with their service on the board in a manner consistent with policy for other state employees.

History.

I.C., § 41-6003, as added by 2010, ch. 32, § 1, p. 60; am. 2018, ch. 32, § 1, p. 59.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Amendments.

The 2018 amendment, by ch. 32, in subsection (2), substituted "ten (10) members" for "nine (9) members" in the introductory paragraph, substituted "Seven (7) members" for "Six (6) members" at the beginning of paragraph (a), rewrote paragraph (a)(iii), which formerly read: "Two (2) members representing the Idaho business community", and, in paragraph (e), substituted "the director's designated representative" for "his designated representative" near the beginning and substituted "eleventh member" for "tenth member" near the end.

Compiler's Notes.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: “The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024.”

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-6004. Plan of operation. [Null and void, effective July 1, 2024.]

— (1) The board shall submit to the director a plan of operation and thereafter any amendments thereto. The plan of operation, and any amendments thereto, shall become effective upon written approval by the director. If the board fails to submit a suitable plan of operation, the director shall adopt and promulgate a temporary plan of operation.

(2) The plan of operation shall: (a) Identify methodology and procedures for determining assessments to the carriers that are fair and equitable; (b) Establish procedures for the director to collect assessments from carriers to fund vaccine purchases by the state of Idaho; and (c) Provide for any additional matters necessary for the implementation and administration of the fund.

(3) Administrative cost associated with the creation and amending the plan of operation shall be paid out of the fund.

History.

I.C., § 41-6004, as added by 2010, ch. 32, § 1, p. 60.

STATUTORY NOTES

Compiler's Notes.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: “The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024.”

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-6005. Power and liability of the board. [Null and void, effective July 1, 2024.] — (1) The board shall have the power to:

- (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including contracts for administrative services;
- (b) Determine the method of assessment and assess carriers in accordance with the provisions of [section 41-6006, Idaho Code](#);
- (c) Require carriers to provide to the board such statements and reports the board deems necessary to fulfill its duties under this chapter;
- (d) Establish policies and procedures as may be necessary or convenient for the implementation of this chapter and the operation of the assessments authorized by this chapter; and
- (e) Consult with the Idaho department of health and welfare and other experts as the board may deem appropriate as necessary or proper to carry out the provisions and purposes of this chapter.

(2) Neither the board nor its members shall be liable for any obligations of the vaccine assessments. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. Participation by a carrier in the assessments authorized by this chapter or on the board under the provisions of this chapter shall not be grounds for any legal action, criminal or civil liability, or penalty against the fund or any of its carriers or board members, either jointly or separately.

History.

[I.C., § 41-6005](#), as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 1, p. 331.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Amendments.

The 2011 amendment, by ch. 121, added “including contracts for administrative services” in paragraph (1)(a) and added paragraph (1)(e).

Compiler’s Notes.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: “The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024.”

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-6006. Assessments. [Null and void, effective July 1, 2024.] — (1) The department of health and welfare shall report to the board on or before January 1 the total number of program-eligible children in the Idaho immunization reminder information system registry who received vaccines, the doses and the total nonvaccine-for-children funds expended for vaccines purchased and administered through the Idaho immunization program for the previous state fiscal year and any other information appropriate or necessary to enable the board to properly determine assessments under the provisions of this chapter.

(2) The assessments to fund vaccine purchases for program-eligible children shall be made annually by the board. Each carrier's proportion of the assessment and the dates upon which the carrier must pay the assessment into the fund shall be determined by the board based on annual statements and other reports deemed necessary by the board. In making the assessment determination, the board shall consider such factors as any surplus funds remaining from a prior assessment, the number and cost of vaccine doses expected to be administered in the pertinent time period and the number of program-eligible children in the pertinent time period, as well as any necessary costs and expenses to administer the fund and discharge the duties of the board. The annual assessment shall be calculated to provide funding that, at a minimum, is expected to be sufficient to cover the administrative costs of the board and fund the purchase of vaccines for program-eligible children that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention on the date the board makes its assessment determination.

(3) For late or nonpayment of assessments by a carrier, the director may impose such penalties as provided in title 41, Idaho Code.

(4) Except as otherwise provided in this subsection, a carrier shall pay an assessment made by the board within sixty (60) days of the notice of assessment being sent to the carrier. For good cause, a carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment if the director

determines that the payment of the assessment would place the carrier in a financially impaired condition, as provided in title 41, Idaho Code. If all or part of an assessment against a carrier is deferred, the amount deferred shall be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving the deferment shall remain liable to the fund for the amount deferred and shall be prohibited from insuring any new individuals in the state of Idaho until such time as it pays the assessments.

(5) The moneys raised by the assessment authorized in this section shall be used solely for the purposes expressly authorized by this chapter.

History.

I.C., § 41-6006, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 2, p. 331; am. 2018, ch. 32, § 2, p. 59.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Amendments.

The 2011 amendment, by ch. 121, in subsection (1), deleted “on or before March 1, 2010, and” following “shall report to the board” and deleted “thereafter” following “January 1” and added “and any other information appropriate or necessary to enable the board to properly determine assessments under the provisions of this chapter”; in subsection (2), added the first sentence, in the third sentence, inserted “any surplus funds remaining from a prior assessment,” “and cost,” and “expected to be” and added the last sentence; deleted former subsection (5), which read: “The initial assessments as determined by the board shall be paid into the fund on or before April 1, 2010”; and redesignated former subsection (6) as present subsection (5).

The 2018 amendment, by ch. 32, substituted “the director may impose such penalties” for “the director shall impose interest at the rate provided by **section 28-22-104(1), Idaho Code**, and may impose such other penalties” in subsection (3).

Compiler's Notes.

For more information on Idaho's immunization reminder information system, referred to in subsection (1), see <https://iris.dhw.idaho.gov/IRIS/portalHeader.do>.

For more information on the advisory committee on immunization practices of the centers for disease control and prevention, referred to at the end of subsection (2), see <https://www.cdc.gov/vaccines/acip/index.html>.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: "The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024."

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-6007. Idaho immunization dedicated vaccine fund. [Null and void, effective July 1, 2024.] — There is hereby created in the state treasury the Idaho immunization dedicated vaccine fund. Moneys in the fund shall be appropriated solely for purposes established by this chapter. All funds in excess to the cost required to perform the administrative functions required under this chapter shall be paid to the Idaho department of health and welfare for the sole purposes of purchasing vaccine for use in the Idaho immunization program. Any moneys in excess of the amount needed to fund the Idaho immunization program for a given period shall be retained by the Idaho department of health and welfare to be used to fund the program in subsequent periods, including a subsequent period after the date this chapter is no longer in effect. The fund and any assessments imposed or collected pursuant to the operation of the fund shall at all times be free from taxation of every kind.

History.

I.C., § 41-6007, as added by 2010, ch. 32, § 1, p. 60; am. 2011, ch. 121, § 3, p. 331.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Amendments.

The 2011 amendment, by ch. 121, in the second sentence, substituted “required to perform the administrative functions required under this chapter” for “required to develop and amend a plan of operation as permitted in **section 41-6004, Idaho Code**” and added the third sentence.

Compiler’s Notes.

For more information on the Idaho immunization program, see <http://healthandwelfare.idaho.gov/Health/IdahoImmunizationProgram/tabid/3767/Default.aspx>.

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: “The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024.”

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

§ 41-6008. Rulemaking authority. [Null and void, effective July 1, 2024.] — Upon consultation with the board, the director shall have the authority to promulgate rules necessary to implement this chapter.

History.

I.C., § 41-6008, as added by 2010, ch. 32, § 1, p. 60.

STATUTORY NOTES

Compiler's Notes.

Section 2 of S.L. 2010, ch. 32 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of remaining portions of this act.”

Section 4 of S.L. 2010, ch. 32, as amended by S.L. 2013, ch. 283, § 1, S.L. 2015, ch. 153, § 1, S.L. 2017, ch. 97, § 1 and further amended by S.L. 2018, ch. 32, § 3 provided: “The provisions of this Chapter 60, Title 41 shall be null, void and of no force and effect on or after July 1, 2024.”

Effective Dates.

Section 3 of S.L. 2010, ch. 32 declared an emergency retroactively to February 1, 2010 and approved March 4, 2010.

Chapter 61

IDAHO HEALTH INSURANCE EXCHANGE ACT

Sec.

41-6101. Short title.

41-6102. Purpose and intent.

41-6103. Definitions.

41-6104. Establishment of the exchange and the board.

41-6105. Powers and authority of the exchange.

41-6106. Report.

41-6107. Relation to other laws.

41-6108. Idaho contractors in a health insurance exchange.

41-6109. Severability.

§ 41-6101. Short title. — This chapter shall be known and may be cited as the “Idaho Health Insurance Exchange Act.”

History.

I.C., § 41-6101, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6102. Purpose and intent. — It is the public policy of the state of Idaho to actively resist federal actions that would limit or override state sovereignty under the 10th amendment of the United States constitution. Through this legislation, the state of Idaho asserts its sovereignty by refusing to surrender decision-making authority over health care issues, which are matters appropriately left to states and individual citizens. The purpose of this chapter is to establish a state-created, market-driven health insurance exchange that will facilitate the selection and purchase of individual and employer health benefit plans. The creation of a state-based health insurance exchange will provide an Idaho-specific solution that fits the unique needs of the state of Idaho. Participation in the exchange is voluntary in that no person or employer shall be required by this chapter to purchase a health benefit plan through the exchange. Creation of the exchange and its operation is deemed a public purpose intended to enhance Idaho residents' choice regarding options and access to health insurance.

History.

I.C., § 41-6102, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6103. Definitions. — For the purposes of this chapter:

(1) “Board” means those individuals who, acting as a board of directors of the exchange, govern and act for the exchange pursuant to [section 41-6104, Idaho Code](#).

(2) “Conflict of interest” means that by taking any action or making any decision or recommendation on a matter within the authority of the board, a member of the board, or a person within the member’s household, or any entity with which the member, or a person within the member’s household is associated, would receive a pecuniary benefit or detriment, unless the pecuniary benefit or detriment would apply to the same degree to a class consisting of all persons within the particular class in this state.

(3) “Director” means the director of the department of insurance of the state of Idaho.

(4) “Exchange” means the Idaho health insurance exchange established pursuant to this chapter.

(5) “Health carrier” has the same meaning as “carrier” as set forth in [section 41-5203\(5\), Idaho Code](#).

(6) “Person” has the same meaning as set forth in [section 41-104, Idaho Code](#).

(7) “Producer” has the same meaning as set forth in [section 41-1003\(8\), Idaho Code](#).

(8) “Stand-alone dental plan” means a policy, certificate of insurance or subscriber contract that provides only dental health plan benefits, which may include adult, pediatric or both, and is approved by the department of insurance as being in compliance with the requirements of state law and departmental rules relating to such policy, certificate of insurance or subscriber contract.

History.

[I.C., § 41-6103](#), as added by 2013, ch. 170, § 1, p. 390; am. 2015, ch. 193, § 1, p. 602.

STATUTORY NOTES

Amendments.

The 2015 amendment, by ch. 193, added subsection (8).

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6104. Establishment of the exchange and the board. — (1) There is hereby created an independent body corporate and politic to be known as the “Idaho Health Insurance Exchange.” Said exchange may exercise the authority and powers conferred by this chapter and such exercise shall be deemed and held to be the performance of an essential public function.

(2) The exchange created by this chapter is not a state agency, shall not be subject to the purchasing statutes and rules of the state of Idaho or subdivisions of the state including, but not limited to, chapters 28 and 57, title 67, Idaho Code, and shall operate subject to the supervision and control of its board.

(3) The board shall consist of nineteen (19) total members, with seventeen (17) voting members. Subject to the provisions of this section, members of the board shall collectively offer expertise, knowledge and experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health and health policy issues related to small employer and individual markets and the uninsured. A majority of the board shall not collectively represent health carriers and producers. The fourteen (14) voting members who are not members of the legislature shall be appointed to the board by, and serve at the pleasure of, the governor. The members appointed to the board by the governor shall be subject to confirmation by the senate, provided that, upon appointment, board members shall have full authority to exercise all the rights and duties and participate in all decisions required of the position. The seventeen (17) voting members of the board shall be appointed as follows:

- (a) Three (3) members representing different health carriers appointed by the governor;
- (b) Two (2) members representing producers appointed by the governor;
- (c) Three (3) members representing individual consumer interests appointed by the governor;
- (d) Four (4) members representing small employer business interests appointed by the governor with, at the time of appointment:

- (i) One (1) member representing small employer business interests employing between one (1) and ten (10) employees;
 - (ii) One (1) member representing small employer business interests employing between eleven (11) and twenty-five (25) employees;
 - (iii) One (1) member representing small employer business interests employing twenty-six (26) or more employees; and
 - (iv) One (1) at-large member;
- (e) Two (2) members representing health care providers appointed by the governor;
- (f) One (1) member of the house of representatives appointed by the speaker of the house;
- (g) One (1) member of the senate appointed by the president pro tempore; and
- (h) One (1) member of the legislature representing the minority party in the legislature appointed by minority leadership.

The director or his designee and the director of the state department of health and welfare or his designee shall each serve as ex officio nonvoting members of the board.

(4) The fourteen (14) board members appointed by the governor shall each serve a term of four (4) years or until a successor is appointed. A board member may be appointed by the governor to serve subsequent terms. A vacancy in a member's position on the board shall be filled in the same manner as the original appointment.

(5) Whenever a member of the board has a conflict of interest on a matter that is before the board, the member shall fully disclose it to the board, abstain from any vote on the matter and shall also comply with any additional requirements established pursuant to the plan of operation under [section 41-6105, Idaho Code](#).

(6) Neither members of the board nor any other person working or performing services for the exchange shall be:

- (a) Considered public officials, employees or agents of the state of Idaho by virtue of their service on the board or performance of services for the

exchange; or

(b) Eligible for or entitled to benefits from the public employee retirement system of Idaho.

(7) Nothing in this chapter shall prevent a member of the board who is otherwise a current or former state employee from receiving his usual state compensation and benefits while serving on the board.

(8) All meetings of the board shall be held in accordance with the open meetings law as provided for in chapter 2, title 74, Idaho Code, shall be held in an open public forum, and every reasonable effort shall be made to make such meetings televised or streamed in video and audio format.

(9) The board shall contract for an annual audit of the exchange by an independent third party and shall accept requests for proposal to bid on such contract.

(10) The board shall develop, adopt and implement procurement policies and guidelines.

(11) Premium rates charged by a health carrier for a health benefit plan or stand-alone dental plan offered in the exchange shall be based upon Idaho rating areas established by the director consistent with [42 U.S.C. section 300gg, et seq.](#)

History.

[I.C., § 41-6104](#), as added by 2013, ch. 170, § 1, p. 390; am. 2017, ch. 58, § 28, p. 91.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Amendments.

The 2017 amendment, by ch. 58, substituted “open meetings law as provided for in chapter 2, title 74, Idaho Code” for “open meeting law as provided for in chapter 23, title 67, Idaho Code” near the beginning of subsection (8).

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6105. Powers and authority of the exchange. — (1) Unless otherwise required by this chapter, in the discretion of the board, the exchange shall have the powers and authority to:

- (a) Perform all duties that are necessary and appropriate to implement a health insurance exchange and the provisions of this chapter;
- (b) Adopt bylaws for the regulation of its affairs and the conduct of its business, subject to the review and approval by the director. The director's consent shall be required for any amendment to the bylaws;
- (c) Assess and collect fees from participating health carriers, exchange users and receive funds from any other source, that shall be used solely for the purposes of this chapter. The exchange shall not be subject to income tax imposed by the state of Idaho under chapter 30, title 63, Idaho Code;
- (d) Appoint any advisory committees as deemed necessary by the board;
- (e) Take any legal action to recover any amounts lawfully owed to the exchange or otherwise consistent with this chapter;
- (f) Enter into contracts to effectuate and implement a health insurance exchange and shall accept requests for proposal to bid on such contracts; and
- (g) Develop, adopt and implement a plan of operation and other governing documents to fulfill the requirements of this chapter.

(2) The exchange powers and authority shall be subject to the following limitations:

- (a) The exchange shall not have the power to alter its own legal structure;
- (b) The exchange shall be financially self-supporting and shall not request any financial support from the state and shall not have the power to tax or encumber state assets;
- (c)(i) The exchange shall be a voluntary marketplace with the purpose of preserving individual choice and facilitating the informed selection and purchase of health benefit plans by eligible individuals, eligible

employers and eligible employees. To that end the exchange portal shall be constructed to permit health insurance shoppers to anonymously input information to comparison shop, and only upon submission of an application require login names, passwords and identifying information.

(ii) Neither the exchange nor any agency of the state of Idaho shall require any person to use or participate in the exchange, nor have the authority to impose upon or collect from a person any penalty for failure or refusal to participate in the exchange or to purchase a health benefit plan or stand-alone dental plan.

(iii) The exchange shall provide as part of the application process for any person qualifying for premium assistance through the exchange a prominent warning advising purchasers to estimate income for the year carefully, that underestimating income can result in an overpayment of premium assistance and that an overpayment of premium assistance will likely result in owing the overpayment back to the internal revenue service.

(d) The exchange shall not prohibit a health carrier from participating in the exchange or prohibit a health benefit plan or stand-alone dental plan from being sold in the exchange so long as the health carrier or health benefit plan or stand-alone dental plan meets all requirements of applicable law and any requirements of the exchange consistent with this chapter;

(e) The exchange shall not prohibit or preclude a health carrier from offering insurance or a stand-alone dental plan outside the exchange;

(f) The exchange shall not prohibit a producer from participating in the exchange, and any producer participating in the exchange shall be entitled to payment for his services through written fee agreements with the individuals or small employers utilizing the services of said producer or through commissions offered by health carriers participating in the exchange;

(g) Before the exchange begins taking applications or collecting information from exchange users, the board shall certify to the director and governor that personal information collected from and about any

person who voluntarily uses the exchange including, but not limited to, health care records and income, is and will continue to be secure;

(h) The exchange shall not inquire about the use, ownership, possession or storage of any firearm or ammunition by anyone using the exchange;

(i) In the event the patient protection and affordable care act (PPACA), [P.L. 111-148](#), or any section thereof or rule enacted thereto, is declared unconstitutional or otherwise invalid by any federal court, unless such ruling is stayed by the court, the exchange shall immediately cease to enforce those affected provisions of the PPACA or rules;

(j) The state of Idaho shall not be liable for any obligations of the exchange; and

(k) The board shall not be liable for any obligations of the exchange. No member of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this chapter, unless such act or omission constitutes willful or wanton misconduct. The board may provide for indemnification of, and legal representation for, its members.

History.

[I.C., § 41-6105](#), as added by 2013, ch. 170, § 1, p. 390; am. 2014, ch. 241, § 1, p. 608.

STATUTORY NOTES

Amendments.

The 2014 amendment, by ch. 241, in paragraph (2), added the paragraph designations, splitting the existing provisions of the subsection between paragraphs (i) and (ii), added the last sentence in paragraph (i), and added subsection (iii).

Federal References.

The patient protection and affordable care act (PPACA), [P.L. 111-148](#), referred to in paragraph (2)(i), is codified throughout the United States Code, especially titles 26 and 42.

Compiler's Notes.

The abbreviations enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6106. Report. — (1) The exchange shall submit a written report of its activities and the condition of the exchange to the director, the governor and the director of the legislative services office for distribution to all legislators on or before January 31, 2014, and annually on or before each January 31 thereafter. The exchange shall also report to the appropriate senate and house of representatives germane committees on any changes to its bylaws or policies and any changes or updates from the federal department of health and human services (HHS) regarding essential health benefits or operation or conditions of the exchange on or before January 31, 2014, and annually on or before each January 31 thereafter.

(2) For any changes by the board to the fee schedule charged to exchange users or participants, the exchange shall, at the next legislative session, report to the appropriate senate and house of representatives germane committees on or before January 31.

History.

I.C., § 41-6106, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Cross References.

Legislative services office, § 67-701 et seq.

Compiler's Notes.

The abbreviations enclosed in parentheses so appeared in the law as enacted.

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall,

upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6107. Relation to other laws. — The board and the exchange are entitled to rely upon work performed by the director and the director of the Idaho department of health and welfare in furtherance of the purpose of this chapter that are not otherwise inconsistent with their respective statutory duties and authority. Nothing in this chapter, and no action taken by the exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the director to regulate the business of insurance within this state pursuant to title 41, Idaho Code, and administer and enforce rules adopted in accordance therewith.

History.

I.C., § 41-6107, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Cross References.

Department of health and welfare, § 56-1001 et seq.

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6108. Idaho contractors in a health insurance exchange. — Pursuant to sections 41-6104 and 41-6105, Idaho Code, the board shall, to the fullest extent practicable, enter into contracts with businesses conducting business in Idaho and employing citizens of this state to staff and provide support for the exchange.

History.

I.C., § 41-6108, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

§ 41-6109. Severability. — The provisions of this act are hereby declared to be severable, and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

History.

I.C., § 41-6109, as added by 2013, ch. 170, § 1, p. 390.

STATUTORY NOTES

Compiler's Notes.

The term “this act” refers to S.L. 2013, Chapter 170, which is codified as §§ 41-6101 to 41-6109.

Effective Dates.

Section 2 of S.L. 2013, ch 170 provided: “An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval. Provided however, that should the Federal Department of Health and Human Services (HHS) and/or the United States Congress change both the establishment date and the eligibility limitation date for the exchange, the Governor shall, upon his determination that such events have occurred, issue a proclamation declaring that Idaho will not be obligated to comply until the new dates are set by HHS and/or the United States Congress. The Governor shall file such proclamation with the Secretary of State.” Approved March 28, 2013.

Chapter 62

IDAHO MOTOR VEHICLE SERVICE CONTRACT ACT

Sec.

41-6201. Short title.

41-6202. Legislative intent.

41-6203. Definitions.

41-6204. Service contract reimbursement policy requirements.

41-6205. Motor vehicle service contract provisions.

41-6206. Motor vehicle service contract requirements.

41-6207. Prohibited acts.

41-6208. Recordkeeping requirements.

41-6209. Licensing.

41-6210. Guaranty.

41-6211. Enforcement and penalties.

§ 41-6201. Short title. — The provisions of this chapter shall be known and may be cited as the “Idaho Motor Vehicle Service Contract Act.”

History.

I.C., § 41-6201, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler’s Notes.

This section is derived from former § 49-2801.

§ 41-6202. Legislative intent. — (1) The legislature finds and declares that a considerable number of Idaho citizens use contracts to provide necessary services for the repair and servicing of motor vehicles purchased and used within the state.

(2) It is the intent of the legislature that this act provides for state of Idaho regulation of motor vehicle service contracts offered for sale in the state by any person other than the motor vehicle manufacturer or its affiliates and subsidiaries.

(3) It is also the intent of the legislature that this act shall not apply to: (a) The customary and usual performance guarantees or warranties offered at no additional charge by motor vehicle manufacturers, or their affiliates and subsidiaries, regarding the sale of motor vehicles; (b) Maintenance agreements; or (c) Theft protection programs or theft protection program warranties.

Such products identified in this subsection shall not be subject to the provisions of title 41, Idaho Code, unless expressly made applicable.

History.

I.C., § 41-6202, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler's Notes.

This section is derived from former § 49-2801.

The term “this act” in subsections (2) and (3) refers to S.L. 2018, Chapter 116, which is codified as §§ 41-6201 through 41-6211 and 41-114A. The reference probably should read “this chapter,” being chapter 62, title 41, Idaho Code.

§ 41-6203. Definitions. — As used in this chapter:

(1) “Administrator” means the person responsible for the administration of the motor vehicle service contract;

(2) “Director” means the director of the Idaho department of insurance;

(3) “Incidental costs” means expenses specified in a theft protection program warranty that are incurred by the warranty holder due to the failure of a theft protection program to perform as provided in the contract. Incidental costs may include, without limitation, insurance policy deductibles, rental vehicle charges, the difference between the actual value of the stolen vehicle at the time of theft and the cost of a replacement vehicle, sales taxes, registration fees, transaction fees and mechanical inspection fees. Incidental costs may be reimbursed in either a fixed amount specified in the theft protection program warranty or by use of a formula itemizing specific incidental costs incurred by the warranty holder;

(4) “Liability insurance policy” means a policy of insurance providing coverage for all contractual obligations incurred by a motor vehicle service contract provider under the terms of a motor vehicle service contract issued or sold by the motor vehicle service contract provider;

(5) “Maintenance agreement” means a contract of limited duration that provides scheduled maintenance only;

(6) “Mechanical breakdown insurance” means a policy, contract or agreement that undertakes to perform or provide repair or replacement service, or indemnification for such service, for the operational or structural failure of a motor vehicle due to defect in materials or workmanship or normal wear and tear and that is issued by an insurance company authorized to do business in this state;

(7) “Motor vehicle service contract” means a contract or agreement given for separately stated consideration that undertakes to perform or provide repair or replacement service, or indemnification for such service, for the operational or structural failure of a motor vehicle due to defect in materials or workmanship or normal wear and tear but shall not include mechanical breakdown insurance. A motor vehicle service contract may provide full or

partial reimbursement for other expenses incurred by the motor vehicle service contract holder as a direct and proximate result of an operational or structural failure or reduced operating efficiency if included in the contract coverage, including but not limited to towing, rental car, lodging, motor club, maintenance benefits, roadside assistance and meal expenses. An agreement whereby an employer or a third party contracted by the employer provides mileage reimbursement and incidental maintenance and repairs to its employees for personal vehicles used for business purposes, which agreement shall not be considered a motor vehicle service contract or a contract of insurance. “Motor vehicle service contract” also means a contract or agreement that provides one (1) or more of the following:

- (a) The repair or replacement of tires, wheels or tires and wheels on a motor vehicle damaged as a result of coming into contact with road hazards;
- (b) The removal of dents, dings or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding or painting;
- (c) The repair of chips or cracks in or the replacement of motor vehicle windshields as a result of damage caused by road hazards; or
- (d) The replacement of a motor vehicle key or key fob in the event that the key or key fob becomes inoperable or is lost or stolen;
- (8) “Motor vehicle service contract holder” means a person who purchases a motor vehicle service contract or is a permitted transferee;
- (9) “Motor vehicle service contract provider” means a person who is contractually obligated to a motor vehicle service contract holder under the terms of a motor vehicle service contract;
- (10) “Person” means an individual, company, association, organization, partnership, business trust, corporation or any other form of legal entity;
- (11) “Road hazard” means a hazard encountered while driving a motor vehicle and may include, but not be limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs or composite scraps;
- (12) “Theft protection program” means a device or system that:

- (a) Is installed on or applied to a motor vehicle;
- (b) Is designed to prevent loss or damage to a motor vehicle from theft;
and
- (c) Includes a theft protection program warranty.

The term shall include, but not be limited to, alarm systems, body part marking products, steering locks, window etch products, pedal and ignition locks, fuel and ignition kill switches, and electronic, radio and satellite tracking devices. The term does not include fuel additives, oil additives or other chemical products applied to the engine, transmission or fuel system, or to interior or exterior surfaces of a motor vehicle;

(13) “Theft protection program warranty” means a written agreement by a warrantor that provides, if a theft protection program fails to prevent loss or damage to a motor vehicle from theft, the warrantor will pay to or on behalf of the warranty holder specified incidental costs as a result of the failure of the theft protection program to perform pursuant to the terms of the theft protection program warranty.

History.

I.C., § 41-6203, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler’s Notes.

This section is derived from former § 49-2802.

§ 41-6204. Service contract reimbursement policy requirements. —

(1) The following are mandatory insurance provisions:

(a) No motor vehicle service contract shall be issued, sold or offered for sale in this state unless the motor vehicle service contract provider is insured under a service contract liability policy issued by an insurer admitted to do business in this state or as otherwise provided in subsection (2) of this section. The policy shall provide that the insurer will pay to or on behalf of the motor vehicle service contract provider all sums the motor vehicle service contract provider is legally obligated to pay according to the motor vehicle service contract provider's contractual obligations under the motor vehicle service contracts issued or sold by the motor vehicle service contract provider; and

(b) All service contract liability policies insuring motor vehicle service contracts issued, sold or offered for sale in this state must conspicuously state that, upon failure of the motor vehicle service contract provider to perform under the contract, the issuer of the policy shall pay on behalf of the provider any sums that the provider is legally obligated to perform according to the provider's contractual obligations under the motor vehicle service contracts issued or sold by the provider.

(2) The service contract liability policy shall be obtained from an insurer authorized, registered or otherwise permitted to transact insurance in this state or a surplus lines insurer meeting the requirements of chapter 12, title 41, Idaho Code, and which insurer or surplus lines insurer meets one (1) of the following requirements:

(a)(i) Maintain surplus as to policyholders and paid-in capital of at least fifteen million dollars (\$15,000,000); and

(ii) Annually file copies of the insurer's audited financial statements, its national association of insurance commissioners (NAIC) annual statement and the actuarial certification required by and filed in the insurer's state of domicile; or

(b)(i) Maintain surplus as to policyholders and paid-in capital of less than fifteen million dollars (\$15,000,000) but at least equal to ten million

dollars (\$10,000,000);

(ii) Maintain a ratio of net written premiums, wherever written, to surplus as to policyholders and paid-in capital of not greater than three (3) to one (1); and

(iii) Annually file copies of the insurer's audited financial statements, its NAIC annual statement and the actuarial certification required by and filed in the insurer's state of domicile.

(3) Premiums are defined as those funds paid by or on behalf of the motor vehicle service contract provider to the liability insurance policy issuer for such risks covered under such liability insurance policy. Such premiums or the method of developing such premiums shall be filed with the director of the department of insurance for approval.

(4) The issuer of a service contract liability policy may not cancel the policy until a thirty (30) days' advance notice of cancellation has been mailed or delivered to each motor vehicle service contract provider. The cancellation of a service contract liability policy shall not reduce the insurer's responsibility for motor vehicle service contracts issued by motor vehicle service contract providers prior to the date of the cancellation.

History.

I.C., § 41-6204, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler's Notes.

This section is derived from former § 49-2803.

§ 41-6205. Motor vehicle service contract provisions. — The following provisions shall apply to the sale of motor vehicle service contracts in the state:

(1) A motor vehicle service contract may not be issued, sold or offered for sale in this state unless the contract contains a statement in substantially the following form: “Obligations of the motor vehicle service contract provider under this motor vehicle service contract are guaranteed under a service contract liability policy. Should the motor vehicle service contract provider fail to pay or provide service on any claim within sixty (60) days after proof of loss has been filed, the motor vehicle service contract holder is entitled to make a claim directly against the insurance company.” The motor vehicle service contract shall also conspicuously state the name and address and a toll-free claim service number of the insurer.

(2) The motor vehicle service contract must identify the motor vehicle service contract provider, the seller and the motor vehicle service contract holder.

(3) The motor vehicle service contract must conspicuously state the total purchase price of the motor vehicle service contract.

(4) If prior approval of repair work is required, the motor vehicle service contract must conspicuously state the procedure for obtaining prior approval and for making a claim, including a toll-free telephone number for claim service and a procedure for obtaining reimbursement for emergency repairs performed outside of normal business hours.

(5) The motor vehicle service contract must conspicuously state the existence of any deductible amount.

(6) The motor vehicle service contract must specify the merchandise and services to be provided and any limitations, exceptions or exclusions. Any preexisting conditions clause must specifically state which preexisting conditions are excluded from coverage.

(7) The motor vehicle service contract must state any terms, restrictions or conditions governing the transferability of the service contract.

(8) The motor vehicle service contract must state the terms, restrictions or conditions governing cancellation of the service contract by either the motor vehicle service contract holder or motor vehicle service contract provider.

(9) A motor vehicle service contract may not be issued, sold or offered for sale in this state unless the contract contains a statement in substantially the following form: “Coverage afforded under this motor vehicle service contract is not guaranteed by the Idaho insurance guaranty association.”

(10) No motor vehicle service contract may be issued, sold or offered in this state unless the service contract conspicuously states that the motor vehicle service contract holder is allowed to cancel the service contract:

(a) Within thirty (30) days of its purchase if no claim has been made and shall receive a full refund of the service contract retail price, less any cancellation fee stated in the service contract not exceeding fifty dollars (\$50.00); or

(b) At any other time and shall receive a pro rata refund of the service contract retail price for the unexpired term of the service contract, based on the number of the lapsed months, miles or such other measure that is clearly disclosed in the service contract, less any cancellation fees stated in the service contract not exceeding fifty dollars (\$50.00).

History.

I.C., § 41-6205, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler’s Notes.

This section is derived from former § 49-2804.

§ 41-6206. Motor vehicle service contract requirements. — Before the sale of any motor vehicle service contract, the motor vehicle service contract provider shall give written notice to the customer clearly disclosing that the purchase of the contract is not required either to purchase or to obtain financing for a motor vehicle. No motor vehicle service contract may be used in this state by any motor vehicle service contract provider if the contract:

(1) In any respect violates, or does not comply with, the laws of this state; (2) Contains or incorporates by reference any inconsistent, ambiguous or misleading clauses or any exceptions and conditions that affect the risk assumed or to be assumed in the general coverage of the contract; (3) Has any title, heading or other indication of its provisions that is misleading; or (4) Is printed or otherwise reproduced in any manner that renders any material provision of the contract substantially illegible.

History.

I.C., § 41-6206, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler's Notes.

This section is derived from former § 49-2805.

§ 41-6207. Prohibited acts. — (1) A motor vehicle service contract provider may not use in its name, contracts or literature:

- (a) Any of the words “insurance,” “casualty,” “surety,” “mutual” or any other words descriptive of the insurance, casualty or surety business; or
- (b) A name deceptively similar to the name or description of any insurance or surety corporation, or any other motor vehicle service contract provider.

(2) A motor vehicle service contract provider, its representative or any other person may not make, permit or allow to be made any false, deceptive or misleading statement, or may not deliberately omit any material statement that would be considered misleading if omitted, in connection with the sale, offer to sell or advertisement of a motor vehicle service contract.

(3) It shall be unlawful for any company to directly or indirectly represent in any manner, whether by written solicitation, advertisement or telemarketing, a false, deceptive or misleading statement with regard to:

- (a) Such company’s affiliation with a motor vehicle manufacturer, recreational vehicle manufacturer or dealer;
- (b) Such company’s possession of information regarding a motor vehicle owner’s current motor vehicle manufacturer’s or recreational vehicle manufacturer’s original equipment warranty;
- (c) All indications that such company’s records show that a motor vehicle or recreational vehicle owner’s current motor vehicle manufacturer’s or recreational vehicle manufacturer’s original equipment warranty is nearing or past expiration;
- (d) A requirement that such motor vehicle or recreational vehicle owner register for a new motor vehicle service contract with such company to maintain coverage under the motor vehicle or recreational vehicle owner’s current service contract or manufacturer’s original equipment warranty.

History.

I.C., § 41-6207, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler's Notes.

This section is derived from former § 49-2806.

§ 41-6208. Recordkeeping requirements. — (1) All motor vehicle service contract providers shall keep accurate accounts, books and records concerning transactions regulated under the provisions of this act. A motor vehicle service contract provider's accounts, books and records shall include:

(a) Copies of all motor vehicle service contracts issued; (b) The name and address of each motor vehicle service contract holder; and (c) Claim files.

(2) All motor vehicle service contract providers shall retain all records pertaining to each motor vehicle service contract holder for at least three (3) years after the specified period of coverage has expired. It shall be the responsibility of the insurer issuing the liability policy to make an examination at least every two (2) years of each motor vehicle service contract provider that they insure to assure that each provider is in compliance with the recordkeeping requirements.

History.

I.C., § 41-6208, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler's Notes.

This section is derived from former § 49-2807.

The term “this act” near the middle of the introductory paragraph in subsection (1) refers to S.L. 2018, Chapter 116, which is codified as §§ 41-6201 through 41-6211 and 41-114A. The reference probably should read “this chapter,” being chapter 62, title 41, Idaho Code.

§ 41-6209. Licensing. — Motor vehicle service contract providers, and persons marketing, administering, selling or offering to sell motor vehicle service contracts for motor vehicle service contract providers, are not required to obtain a license under title 41, Idaho Code. A motor vehicle service contract provider shall not be subject to regulation under any provision of title 41, Idaho Code, not made expressly applicable to it.

History.

I.C., § 41-6209, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler's Notes.

This section is derived from former § 49-2809.

§ 41-6210. Guaranty. — The provisions of the Idaho insurance guaranty association act, chapter 36, title 41, Idaho Code, shall not apply to any motor vehicle service contract, mechanical breakdown insurance or motor vehicle service contract liability insurance policy, as defined in this chapter, and no claim under any motor vehicle service contract, mechanical breakdown insurance or motor vehicle service contract liability insurance policy shall be deemed to be a “covered claim” within the scope of [section 41-3605\(7\), Idaho Code](#), as to which the Idaho insurance guaranty association has any obligation under [section 41-3608, Idaho Code](#), or other provisions of chapter 36, title 41, Idaho Code.

History.

[I.C., § 41-6210](#), as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler’s Notes.

This section is derived from former § 49-2810.

§ 41-6211. Enforcement and penalties. — (1) The director may conduct examinations of motor vehicle service contract providers, administrators, insurers or other persons to enforce the provisions of this chapter and to protect motor vehicle service contract holders in this state. Upon request of the director, the provider shall make available to the director all accounts, books and records concerning motor vehicle service contracts sold or issued by the provider that are necessary to enable the director to reasonably determine compliance or noncompliance with this chapter.

(2) The following provisions of chapter 2, title 41, Idaho Code, generally addressing the director's inquiry powers, orders and conduct of administrative proceedings apply to persons subject to this chapter:

- (a) Sections 41-210 through 41-215, Idaho Code;
- (b) Sections 41-220 through 41-223, 41-225, and 41-227, Idaho Code; and
- (c) Sections 41-229 through 41-240, and section 41-247, Idaho Code.

(3) Any company that violates any provisions of this act may, in the director's discretion, be subject to a civil penalty of one thousand dollars (\$1,000) per violation, limited to a total of twenty-five thousand dollars (\$25,000) in the aggregate for all like violations.

(4) This act does not create a separate civil cause of action, but does not preclude a cause of action under the Idaho consumer protection act, chapter 6, title 48, Idaho Code, or any applicable common law or statutory causes of action.

History.

I.C., § 41-6211, as added by 2018, ch. 116, § 2, p. 241.

STATUTORY NOTES

Compiler's Notes.

This section is derived from former §§ 49-2805A and 49-2811.

The term “this act” in subsections (3) and (4) refers to S.L. 2018, Chapter 116, which is codified as §§ 41-6201 through 41-6211 and 41-114A. The reference probably should read “this chapter,” being chapter 62, title 41, Idaho Code.

Chapter 63

OWN RISK AND SOLVENCY ASSESSMENT

Sec.

41-6301. Purpose and scope.

41-6302. Definitions.

41-6303. Risk management framework.

41-6304. ORSA requirement.

41-6305. ORSA summary report.

41-6306. Exemption.

41-6307. Contents of ORSA summary report.

41-6308. Confidentiality.

§ 41-6301. Purpose and scope. — (1) The purpose of this chapter is to provide the requirements for maintaining a risk management framework and completing an own risk and solvency assessment (ORSA) and provide guidance and instructions for filing an ORSA summary report with the director of the state department of insurance.

(2) The requirements of this chapter shall apply to all insurers domiciled in this state unless exempt pursuant to [section 41-6306, Idaho Code](#).

(3) The legislature finds and declares that the ORSA summary report will contain confidential and sensitive information related to an insurer's or an insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of the legislature that the ORSA summary report shall be a confidential document filed with the director, that the ORSA summary report will be shared only as stated herein and to assist in the performance of the director's duties, and that in no event shall the ORSA summary report be subject to public disclosure.

History.

[I.C., § 41-6301](#), as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler's Notes.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownrisksolvencyassessment.htm>.

Section 4 of S.L. 2017, ch. 75 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act".

§ 41-6302. Definitions. — For purposes of this chapter:

- (1) “Department” means the state department of insurance.
- (2) “Director” means the director of the state department of insurance.
- (3) “Insurance group” means, for the purpose of conducting an ORSA, those insurers and affiliates included within an insurance holding company system as defined in [section 41-3802, Idaho Code](#).
- (4) “Insurer” has the same meaning as set forth in [section 41-103, Idaho Code](#), and shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state. For purposes of this chapter, the term “insurer” includes, but is not limited to:
 - (a) An entity holding a certificate of authority under chapter 3, title 41, Idaho Code;
 - (b) A service corporation holding a certificate of authority under chapter 34, title 41, Idaho Code;
 - (c) A managed care organization holding a certificate of authority under chapter 39, title 41, Idaho Code; and
 - (d) The state insurance fund created under chapter 9, title 72, Idaho Code.
- (5) “Own risk and solvency assessment” or “ORSA” means a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer’s or the insurance group’s current business plan, and the sufficiency of capital resources to support those risks.
- (6) “ORSA guidance manual” means the current version of the own risk and solvency assessment guidance manual developed and adopted by the national association of insurance commissioners (NAIC) and as amended from time to time and utilizing the version of the manual adopted by the director by rule, administrative order or bulletin.

(7) “ORSA summary report” means a confidential high-level summary of an insurer’s or an insurance group’s ORSA.

History.

I.C., § 41-6302, as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler’s Notes.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownrisksolvencyassessment.htm>.

Section 4 of S.L. 2017, ch. 75 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6303. Risk management framework. — An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

History.

I.C., § 41-6303, as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler's Notes.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownrisksolvencyassessment.htm>.

Section 4 of S.L. 2017, ch. 75 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6304. ORSA requirement. — Subject to [section 41-6306, Idaho Code](#), an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA guidance manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

History.

[I.C., § 41-6304](#), as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler's Notes.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownrisksolvencyassessment.htm>.

Section 4 of S.L. 2017, ch. 75 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6305. ORSA summary report. — (1) Upon the director's request, and no more than once each year, an insurer shall submit to the director an ORSA summary report or any combination of reports that together contain the information described in the ORSA guidance manual, applicable to the insurer and/or the insurance group of which the insurer is a member. If the insurer is a member of an insurance group, the insurer shall submit the report(s) required by this subsection if the director is the lead state director of the insurance group as determined by the procedures within the financial analysis handbook adopted by the NAIC and as adopted by the director by rule, administrative order or bulletin.

(2) The report(s) shall include a signature of the insurer's or the insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of the officer's or executive's belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer may comply with subsection (1) of this section by providing the most recent and substantially similar report(s) provided by the insurer or another member of an insurance group of which the insurer is a member to the director or commissioner of another state or to a supervisor or regulator of a foreign jurisdiction if that report provides information that is comparable to the information described in the ORSA guidance manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

History.

I.C., § 41-6305, as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler's Notes.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownrisksolvency>

assessment.htm.

Section 4 of S.L. 2017, ch. 75 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6306. Exemption. — (1) An insurer shall be exempt from the requirements of this chapter if:

(a) The insurer has an annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, less than five hundred million dollars (\$500,000,000); and

(b) The insurance group of which the insurer is a member has an annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, less than one billion dollars (\$1,000,000,000).

(2) If an insurer qualifies for exemption pursuant to subsection (1)(a) of this section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to subsection (1)(b) of this section, then the ORSA summary report that may be required pursuant to [section 41-6305, Idaho Code](#), shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one (1) ORSA summary report for any combination of insurers, provided any combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to subsection (1)(a) of this section, but the insurance group of which the insurer is a member qualifies for exemption pursuant to subsection (1)(b) of this section, then the only ORSA summary report that may be required pursuant to [section 41-6305, Idaho Code](#), shall be the report applicable to that insurer.

(4) An insurer that does not qualify for exemption pursuant to subsection (1) of this section may apply to the director for a waiver from the requirements of this chapter based upon unique circumstances. In deciding whether to grant the insurer's request for a waiver, the director may consider the type and volume of business written, ownership and organizational structure, and any other factor the director considers relevant to the insurer or insurance group of which the insurer is a member. If the

insurer is part of an insurance group with insurers domiciled in more than one (1) state, the director shall coordinate with the lead state director or commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemptions stated in this section:

(a) The director may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests and international supervisor requests.

(b) The director may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report if the insurer has risk-based capital for company action level event as set forth in [section 41-5403, Idaho Code](#), meets one (1) or more of the standards of an insurer deemed to be in hazardous financial condition as defined in [IDAPA 18.01.66](#), "director's authority for companies deemed to be in hazardous financial condition," or otherwise exhibits qualities of a troubled insurer as determined by the director.

(6) If an insurer that qualifies for an exemption pursuant to subsection (1) of this section subsequently no longer qualifies for that exemption due to changes in premium, as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one (1) year following the year the threshold is exceeded to comply with the requirements of this chapter.

History.

[I.C., § 41-6306](#), as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler's Notes.

For more information on the federal crop insurance corporation, referred to in paragraphs (1)(a) and (1)(b), see <https://www.rma.usda.gov/FCIC/>.

For more information on the federal flood program (the national flood insurance program), referred to in paragraphs (1)(a) and (1)(b), see <https://www.fema.gov/national-flood-insurance-program>.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownrisksolvencyassessment.htm>.

Section 4 of S.L. 2017, ch. 75 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6307. Contents of ORSA summary report. — (1) The ORSA summary report shall be prepared consistent with the ORSA guidance manual, subject to the requirements of subsection (2) of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the director.

(2) The review of the ORSA summary report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

History.

I.C., § 41-6307, as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler's Notes.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownriskssolvencyassessment.htm>.

Section 4 of S.L. 2017, ch. 75 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6308. Confidentiality. — (1) Documents, materials or other information, including the ORSA summary report, in the possession of or control of the department that are obtained by, created by or disclosed to the director or any other person under this chapter are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to disclosure pursuant to the public records act, chapter 1, title 74, Idaho Code, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

(2) Neither the director nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the director, or with whom such documents, materials or other information are shared pursuant to this chapter, shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the director's regulatory duties, the director:

(a) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, subject to subsection (1) of this section, with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in [section 41-3815, Idaho Code](#), with the NAIC and with any third-party consultants designated by the director, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality.

(b) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in [section 41-3815, Idaho Code](#), and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(c) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this chapter, consistent with paragraphs (a) and (b) of this subsection, that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this chapter, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this chapter remains with the director and the NAIC's or a third-party consultant's use of the information is subject to the direction of the director;

(iii) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(iv) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this chapter is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

(v) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this chapter; and

(vi) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(4) The sharing of information and documents by the director pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the director is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the director under this section or as a result of sharing as authorized in this chapter.

(6) Documents, materials or other information in the possession or control of the NAIC or third-party consultants pursuant to this chapter shall be confidential by law and privileged, shall not be subject to the public records act, chapter 1, title 74, Idaho Code, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

History.

I.C., § 41-6308, as added by 2017, ch. 75, § 1, p. 188.

STATUTORY NOTES

Compiler's Notes.

For more information on own risk and solvency assessment, see <http://www.naic.org/ciprtopics/topicownrisksolvencyassessment.htm>.

Section 4 of S.L. 2017, ch. 75 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is

declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

Chapter 64

CORPORATE GOVERNANCE ANNUAL DISCLOSURE

Sec.

41-6401. Purpose and scope.

41-6402. Definitions.

41-6403. Disclosure requirement.

41-6404. Contents of corporate governance annual disclosure.

41-6405. Confidentiality.

41-6406. NAIC and third-party consultants.

§ 41-6401. Purpose and scope. — (1) The purpose and scope of this chapter are to:

- (a) Provide the insurance director a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the director to gain and maintain an understanding of the insurer's corporate governance framework;
- (b) Outline the requirements for completing a corporate governance annual disclosure with the insurance director; and
- (c) Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information that, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(2) Nothing in this chapter shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Nothing in this chapter shall be construed to limit the director's authority, or the rights or obligations of third parties, under applicable examination authority including, but not limited to, sections 41-219 and 41-3814, Idaho Code.

(3) The requirements of this chapter shall apply to all insurers domiciled in this state.

History.

I.C., § 41-6401, as added by 2017, ch. 77, § 1, p. 209.

STATUTORY NOTES

Compiler's Notes.

Section 4 of S.L. 2017, ch. 77 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is

declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6402. Definitions. — As used in this chapter:

(1) “Corporate governance annual disclosure” or “CGAD” means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this chapter.

(2) “Insurance group” means those insurers and affiliates included within an insurance holding company system as that term is defined in chapter 38, title 41, Idaho Code.

(3) “Insurer” has the same meaning as set forth in [section 41-103, Idaho Code](#), and it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state. For purposes of this chapter, the term “insurer” includes, but is not limited to: (a) An entity holding a certificate of authority under chapter 3, title 41, Idaho Code; (b) A service corporation holding a certificate of authority under chapter 34, title 41, Idaho Code; (c) A managed care organization holding a certificate of authority under chapter 39, title 41, Idaho Code; and (d) The state insurance fund, created under chapter 9, title 72, Idaho Code.

History.

[I.C., § 41-6402](#), as added by 2017, ch. 77, § 1, p. 209.

STATUTORY NOTES

Compiler’s Notes.

Section 4 of S.L. 2017, ch. 77 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6403. Disclosure requirement. — (1) A domestic insurer, or the insurance group of which the domestic insurer is a member, shall, no later than June 1 of each calendar year, submit to the director a corporate governance annual disclosure (CGAD) that contains the information described in [section 41-6404, Idaho Code](#). Absent a request from the director pursuant to subsection (3) of this section, an insurance group is not required to submit the CGAD if Idaho is not the lead state for the insurance group, as determined by the procedures outlined in the most recent national association of insurance commissioners' (NAIC) financial analysis handbook adopted by the director by rule, administrative order or bulletin.

(2) The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary, attorney in fact, executive administrator, or other officer having responsibility for the insurer's or insurance group's compliance with governance structure, practices and policies attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer or insurance group not required to submit a CGAD under subsection (1) of this section shall do so upon the director's request.

(4) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three (3) criteria was used to

determine the level of reporting and explain any subsequent changes in the level of reporting.

(5) The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent financial analysis handbook referenced in subsection (1) of this section.

(6) Insurers providing information substantially similar to the information required by this chapter in other documents provided to the director, including proxy statements filed in conjunction with form B requirements or other state or federal filings provided to the department, shall not be required to duplicate that information in the CGAD but shall only be required to cross-reference the document in which the information is included.

History.

I.C., § 41-6403, as added by 2017, ch. 77, § 1, p. 209.

STATUTORY NOTES

Compiler's Notes.

Section 4 of S.L. 2017, ch. 77 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act".

§ 41-6404. Contents of corporate governance annual disclosure. —

(1) The insurer or insurance group shall have discretion over the responses to the CGAD inquiries, provided the CGAD shall contain the material information necessary to permit the director to gain an understanding of the insurer's or group's corporate governance structure, policies and practices including, without limitation, information concerning policies and practices of the board of directors, the senior governing entity and significant committees thereof, the policies and practices for directing senior management, and the processes by which the board of directors, the senior governing entity, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities. The director may request additional information that the director deems material and necessary to provide the director with a clear understanding of the corporate governance policies, the reporting or information system, or the controls implementing those policies.

(2) The CGAD shall be prepared consistent with any rules promulgated by the director. Documentation and supporting information shall be maintained and made available upon examination or upon request of the director.

(3) Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

History.

I.C., § 41-6404, as added by 2017, ch. 77, § 1, p. 209.

STATUTORY NOTES

Compiler's Notes.

Section 4 of S.L. 2017, ch. 77 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act

or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6405. Confidentiality. — (1) Documents, materials or other information, including the CGAD, in the possession or control of the department of insurance that are obtained by, created by or disclosed to the director or any other person under this chapter are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to disclosure pursuant to the provisions of chapter 1, title 74, Idaho Code, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the director may share or receive confidential documents, materials or other CGAD-related information pursuant to subsection (3) of this section to assist in the performance of the director's duties.

(2) Neither the director nor any person who received documents, materials or other CGAD-related information, through examination or otherwise, while acting under the authority of the director, or with whom such documents, materials or other information are shared pursuant to this chapter, shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the director's regulatory duties, the director may:

(a) Upon request, share documents, materials, or other CGAD-related information including the confidential and privileged documents, materials, or information subject to subsection (1) of this section, including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as discussed in [section 41-3815](#),

Idaho Code, with the NAIC, and with third-party consultants pursuant to section 41-6406, Idaho Code, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(b) Receive documents, materials, or other CGAD-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as discussed in section 41-3815, Idaho Code, and from the NAIC, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) The sharing of information and documents by the director pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the director is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the director under this section or as a result of sharing as authorized in this chapter.

History.

I.C., § 41-6405, as added by 2017, ch. 77, § 1, p. 209.

STATUTORY NOTES

Compiler's Notes.

For more information on the national association of insurance commissioners (NAIC), referred to in paragraphs (3)(a) and (3)(b), see <http://www.naic.org/>.

Section 4 of S.L. 2017, ch. 77 provided: “Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act”.

§ 41-6406. NAIC and third-party consultants. — (1) The director may retain third-party consultants not otherwise part of the director's staff as may be reasonably necessary to assist the director in reviewing the CGAD and related information or the insurer's compliance with this chapter.

(2) Any persons retained under subsection (1) of this section shall be under the direction and control of the director and shall act in a purely advisory capacity.

(3) The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the director.

(4) As part of the retention process, a third-party consultant shall verify to the director, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this chapter.

(5) A written agreement with the NAIC and/or a third-party consultant governing sharing and use of information provided pursuant to this chapter shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this chapter:

(a) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this chapter;

(b) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(c) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the department of insurance and the NAIC's or third-party

consultant's use of the information is subject to the direction of the director;

(d) A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(e) A provision requiring the NAIC or third-party consultant to provide prompt notice to the director and to the insurer or insurance group regarding any subpoena, request for disclosure or request for production of the insurer's CGAD-related information; and

(f) A requirement that the NAIC or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this chapter.

History.

I.C., § 41-6406, as added by 2017, ch. 77, § 1, p. 209.

STATUTORY NOTES

Compiler's Notes.

For more information on the national association of insurance commissioners (NAIC), referred to throughout this section, see <http://www.naic.org/>.

Section 4 of S.L. 2017, ch. 77 provided: "Severability. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act".

Chapter 65

COVERAGE FOR PARTICIPANTS IN CLINICAL TRIALS

Sec.

41-6501. “Routine patient care costs” defined.

41-6502. Required coverage.

41-6503. Research institutions.

41-6504. Limitations on coverage.

41-6505. Insurer liability.

41-6506. Deductible, coinsurance, and copayment requirements.

41-6507. Cancellation or nonrenewal prohibited.

§ 41-6501. “Routine patient care costs” defined. — “Routine patient care costs” means the costs of any medically necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the enrollee is participating in a clinical trial. Routine patient care costs do not include the cost:

(1) Of an investigational new drug or device that is not approved for any indication by the United States food and drug administration; (2) Of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial; (3) Of a service that is inconsistent with widely accepted and established standards of care for a particular diagnosis; (4) Associated with managing a clinical trial; or (5) Of a health care service that is specifically excluded from coverage under a health benefit plan.

History.

I.C., § 41-6501, as added by 2019, ch. 192, § 1, p. 604.

§ 41-6502. Required coverage. — The issuer of a health benefit plan shall provide benefits for routine patient care costs to an enrollee in connection with an approved clinical trial. For purposes of this chapter, “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of a disease or condition and:

(1) The study or investigation is approved or funded, which may include funding through in-kind contributions, by one (1) or more of the following:

(a) The national institutes of health;

(b) The centers for disease control and prevention;

(c) The agency for healthcare research and quality;

(d) The centers for medicare and medicaid services;

(e) A cooperative group or center of any of the entities through the department of defense or the department of veterans affairs; or (f) A qualified nongovernmental research entity identified in the guidelines issued by the national institutes of health for center support grants;

(2) The study or investigation is conducted under an investigational new drug application reviewed by the food and drug administration; (3) The study or investigation is not a new drug trial and therefore exempt from having such an investigational new drug application by the food and drug administration; or (4) The study or investigation has been reviewed and approved by an institutional review board of an institution that has an agreement with the office for human research protections of the United States department of health and human services.

History.

I.C., § 41-6502, as added by 2019, ch. 192, § 1, p. 604.

STATUTORY NOTES

Compiler’s Notes.

For further information on the national institutes of health, referred to in paragraph (1)(a), see <https://www.nih.gov>.

For further information on the centers for disease control and prevention, referred to in paragraph (1)(b), see <https://www.cdc.gov>.

For further information on the agency for healthcare research and quality, referred to in paragraph (1)(c), see <https://www.ahrq.gov>.

For further information on the centers for medicare and medicaid services, referred to in paragraph (1)(d), see <https://www.cms.gov>.

For further information on the office for human research protections of the United States department of health and human services, referred to in subsection (4), see <https://www.hhs.gov/ohrp>.

§ 41-6503. Research institutions. — The issuer of a health benefit plan is not required to:

(1) Reimburse a research institution conducting a clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under the health benefit plan at the rates established under the plan as payment in full for the routine patient care provided in connection with the clinical trial; or

(2) Provide benefits under this section for services that are customarily paid for by the research institution conducting the clinical trial in accordance with centers for medicare and medicaid services billing guidelines.

History.

I.C., § 41-6503, as added by 2019, ch. 192, § 1, p. 604.

STATUTORY NOTES

Compiler's Notes.

For further information on the centers for medicare and medicaid services, referred to in subsection (2), see <https://www.cms.gov>.

§ 41-6504. Limitations on coverage. — The issuer of a health benefit plan is not required to provide benefits for routine patient care services provided outside:

(1) Of the plan's health care provider network, unless out-of-network benefits are otherwise provided under the plan; or

(2) This state, unless the health benefit plan otherwise provides benefits for health care services provided outside this state.

History.

I.C., § 41-6504, as added by 2019, ch. 192, § 1, p. 604.

§ 41-6505. Insurer liability. — An insurer that provides coverage required by this chapter is not, based on that coverage, liable for any adverse effects of the approved clinical trial.

History.

I.C., § 41-6505, as added by 2019, ch. 192, § 1, p. 604.

§ 41-6506. Deductible, coinsurance, and copayment requirements. — Benefits may be made subject to a deductible, coinsurance, or copayment requirement comparable to other deductible, coinsurance, or copayment requirements applicable under the health benefit plan.

History.

I.C., § 41-6506, as added by 2019, ch. 192, § 1, p. 604.

§ 41-6507. Cancellation or nonrenewal prohibited. — The issuer of a health benefit plan may not cancel or refuse to renew coverage under a plan solely because an enrollee in the plan participates in a clinical trial.

History.

I.C., § 41-6507, as added by 2019, ch. 192, § 1, p. 604.

Table of Contents

Prefatory Material	2
Title Page	2
Copyright Page	4
Terms of Use	5
User's Guide	7
Adjournment Dates of Sessions of Legislature	8
Title 41 INSURANCE	12
Chapter 1 SCOPE OF INSURANCE CODE — GENERAL PROVISIONS	14
§ 41-101. Short title.	17
§ 41-102. "Insurance" defined.	18
§ 41-103. "Insurer" defined.	19
§ 41-104. "Person" defined.	20
§ 41-105. "Director," "department" defined.	21
§ 41-106. "Domestic," "foreign," "alien" insurer defined.	22
§ 41-107. "State" defined.	23
§ 41-108. "Domicile" defined.	24
§ 41-109. "Principal office" defined.	25
§ 41-110. "Authorized," "unauthorized" insurer defined.	26
§ 41-111. "Certificate of authority," "license" defined.	27
§ 41-112. "Transacting insurance" defined.	28
§ 41-113. Compliance required — Public interest.	30
§ 41-114. Application of code as to particular types of insurers.	31
§ 41-114A. Service contracts.	33
§ 41-114B. Legal service expense plans.	35
§ 41-115. Particular provisions prevail.	36
§ 41-116. Captions not to affect meaning.	37

§ 41-117. General penalty.	38
§ 41-117A. Penalty for transacting insurance without proper licensing.	39
§ 41-118. “Chapter” defined.	40
§ 41-119. Applicability of code under unrepealed laws.	41
§ 41-120. Charitable gift annuities.	42
§ 41-121. Exemption of health care sharing ministries from the insurance code.	45
Chapter 2 THE DEPARTMENT OF INSURANCE	47
§ 41-201. Department of insurance.	52
§ 41-202. Director — Appointment — Term — Qualifications.	54
§ 41-203. Terms construed.	55
§ 41-204. Director’s oath and bond.	56
§ 41-205. Official seal.	57
§ 41-206. Divisions and employees.	58
§ 41-207. Delegation of powers.	59
§ 41-208. Prohibited interests, rewards.	60
§ 41-209. Professional services.	62
§ 41-210. General powers, duties.	63
§ 41-211. Rules.	65
§ 41-212. Orders, notices.	67
§ 41-213. Enforcement.	69
§ 41-214. Records — Reproduction — Destruction.	71
§ 41-215. Use of reproductions and certified copies as evidence.	72
§ 41-216. Director’s annual report.	73
§ 41-217. Publications authorized.	75
§ 41-218. Publications — Sale.	76
§ 41-219. Examination of insurers.	77
§ 41-220. Examination of agents, brokers, consultants, managers, adjusters, promoters.	79

§ 41-221. Place of examination.	80
§ 41-222. Examination cooperation with other states.	81
§ 41-223. Conduct of examination — Access to records — Correction of accounts — Removal of records.	82
§ 41-224. Examination — Appraisal of asset.	84
§ 41-225. Obstruction of examination — Penalty.	85
§ 41-226. Examiners — Qualifications.	86
§ 41-227. Examination report.	88
§ 41-228. Examination expense.	92
§ 41-229. Witnesses and evidence.	94
§ 41-230. Testimony compelled — Immunity from prosecution.	96
§ 41-231. Hearings and appeal — Scope of provisions.	98
§ 41-232. Hearings in general.	99
§ 41-232A. Hearings upon the denial, nonrenewal, suspension or revocation of a certificate of authority or license or imposition of administrative penalties.	101
§ 41-233. Stay of action. [Repealed.]	102
§ 41-234. Place of hearing — Admission of public.	103
§ 41-235. Notice of hearing.	104
§ 41-236. Show cause notice.	105
§ 41-237. Adjourned hearing.	106
§ 41-238. Nonattendance.	107
§ 41-239. Hearing procedure. [Repealed.]	108
§ 41-240. Order on hearing.	109
§ 41-241. Appeals from the director. [Repealed.]	111
§ 41-242. Method of appeal. [Repealed.]	112
§ 41-243—41-245. Record to court — Hearing the appeal — Stay of action on appeal. [Repealed.]	113
§ 41-246. Appeals to Supreme Court. [Repealed.]	114
§ 41-247. Inquiry powers of director.	115
§ 41-248. Interstate relations.	116

§ 41-249. Sharing of information among governmental agencies and the national association of insurance commissioners.	117
§ 41-250. [Amended and Redesignated.]	119
§ 41-251. Civil liability. [Repealed.]	120
§ 41-252. Cooperation between the director of the department of insurance and the director of the department of law enforcement. [Repealed.]	121
§ 41-253. Statement of purpose — Adoption of international fire code.	122
§ 41-254. Powers and duties of state fire marshal — International fire code, enforcement and regulations — Reports.	124
§ 41-255. Duties of state fire marshal.	126
§ 41-256. Assistants to state fire marshal — Local appeal procedure.	128
§ 41-257. State fire marshal as chief arson investigation officer.	129
§ 41-258. Report of losses by fire insurance companies to state fire marshal.	130
§ 41-259. Inspection of buildings — Order of remedy or removal — Service of order.	131
§ 41-260. Appeal from order of remedy or removal — Appeal from local appeal decision.	133
§ 41-261. Failure to comply with order of remedy or removal — Failure to comply with local decision or local appeal decision — Penalty — Civil action to recover penalty.	135
§ 41-262. Failure to comply with order of remedy or removal — Repair or demolition of premises — Expense.	137
§ 41-263. Failure to pay expense of repair or demolition — Assessment.	138
§ 41-264. Investigative hearings — Subpoena of witnesses — Conduct of hearing.	140
§ 41-265. Witness fees — Charge for service of process.	141

§ 41-266. Admission of international fire code in evidence.	142
§ 41-267. Hardship resulting from application of act — Adjustments and variances. [Repealed.]	143
§ 41-268. Arson, fire and fraud prevention account.	144
§ 41-269. Liberal construction of act.	146
§ 41-270. [Amended and Redesignated.]	147
§ 41-271. [Amended and Redesignated.]	148
§ 41-272. [Amended and Redesignated.]	149
§ 41-273. [Amended and Redesignated.]	150
§ 41-274. [Amended and Redesignated.]	151
§ 41-275. [Reserved.]	152
§ 41-276—41-285. Underground Storage Tank Technician Certification Act. [Repealed.]	152
§ 41-286. Uniform claims processing.	153
§ 41-287. Application of provisions adopted by national association of insurance commissioners.	154
§ 41-288. Retaliatory requirement.	155
§ 41-290. Fraudulent claims.	156
§ 41-291. Definitions.	157
§ 41-292. Disclosure of information by insurers.	160
§ 41-293. Insurance fraud.	163
§ 41-294. Damage to or destruction of insured property.	168
§ 41-295. Duties of the investigation section.	170
§ 41-296. Confidentiality — Compulsory testimony.	172
§ 41-297. Disclosure requirements.	173
§ 41-298. Jurisdiction — Construction of provisions.	174
Chapter 3 AUTHORIZATION OF INSURERS AND GENERAL REQUIREMENTS	175
§ 41-301. “Stock” insurer defined.	179
§ 41-302. “Mutual” insurer defined.	180
§ 41-302A. “Deposit guarantee” corporation defined.	181
§ 41-303. “Reciprocal” insurer defined.	182

§ 41-304. “Charter” defined.	183
§ 41-305. Certificate of authority required.	184
§ 41-306. Exceptions to certificate of authority requirement.	186
§ 41-306A. Interstate insurance sales.	188
§ 41-307. Authorization for investment purposes only.	190
§ 41-308. General eligibility for certificate of authority.	191
§ 41-309. Government-owned insurers not to be authorized.	193
§ 41-310. Payment of back taxes.	195
§ 41-311. Name of insurer.	196
§ 41-312. Combinations of insuring powers — One insurer.	198
§ 41-313. Capital funds required — Foreign insurers and new domestic insurers.	199
§ 41-313A. Domestic reciprocal insurers with fewer than seven subscribers.	202
§ 41-314. Capital funds required — Old domestic insurers. [Repealed.]	203
§ 41-315. Permissible insuring combinations without additional capital funds.	204
§ 41-316. Deposit — Foreign or alien insurers.	206
§ 41-316A. Deposit — General requirement — Domestic insurers.	209
§ 41-317. Special deposit — Workmen’s compensation insurers. [Repealed.]	210
§ 41-318. Cooperation with the department of health and welfare.	211
§ 41-319. Application for certificate of authority.	213
§ 41-320. Consideration of application.	217
§ 41-321. Filing of articles of incorporation. [Repealed.]	218
§ 41-322. Issuance or refusal of certificate of authority.	219
§ 41-322A. Certificates of authority for deposit guarantee corporations.	220
§ 41-323. What certificate evidences — Ownership of certificate.	221

§ 41-324. Continuance, expiration, or reinstatement of certificate of authority.	222
§ 41-325. Amendment of certificate of authority.	224
§ 41-326. Suspension or revocation of certificate of authority — Mandatory grounds.	225
§ 41-327. Administrative penalty — Suspension or revocation of certificate of authority — Discretionary and special grounds.	226
§ 41-328. Order and notice of suspension, revocation or refusal — Effect upon agents' authority.	229
§ 41-329. Duration of suspension — Insurer's obligations during suspension period — Reinstatement.	230
§ 41-330. Impaired insurers — Notice to agents — Penalty.	232
§ 41-331. Impaired insurers — Liability of officers.	234
§ 41-332. Foreign insurers exempt from corporation laws governing admission of foreign corporations.	235
§ 41-333. Director as process agent for foreign insurers and domestic reciprocal insurers.	236
§ 41-334. Serving process — Time to plead.	239
§ 41-335. Annual statement.	240
§ 41-336. Review of annual statement — Additional information.	242
§ 41-336A—41-336D. Statistical reports — Disposition — Penalties — Fees. [Repealed.]	243
§ 41-337. Resident agent, countersignature law.	244
§ 41-338. Exceptions to resident agent, countersignature law.	247
§ 41-339. Affidavit of compliance with resident agent, countersignature law. [Repealed.]	249
§ 41-340. Retaliatory provision.	250
§ 41-341. Operational standards between insurer, its parent corporation, subsidiary or affiliated person.	253
§ 41-342. Redomestication as a domestic insurer — Conversion to foreign insurer.	254
§ 41-343. Articles of redomestication.	256

§ 41-344. Effective date of redomestication.	258
§ 41-345. Report.	259
§ 41-346. Acquisitions and dispositions of assets.	261
§ 41-347. Nonrenewals, cancellations or revisions of ceded reinsurance agreements.	263
§ 41-348. Prohibited acts — Service providers.	266
§ 41-349. Pharmacy benefit managers.	267
Chapter 4 FEES AND TAXES	269
§ 41-401. Fees — Licenses — Miscellaneous charges.	271
§ 41-402. Premium tax.	274
§ 41-402A. Refunds.	278
§ 41-403. Reduced tax based on Idaho investments.	279
[Repealed.]	
§ 41-403A. Notice of intent to claim reduced premium tax rate. [Repealed.]	280
§ 41-404. Penalty for failure to pay tax.	281
§ 41-405. Premium tax in lieu of other taxes — Local taxes prohibited.	282
§ 41-406. Deposit and report of fees, licenses and taxes.	284
Chapter 5 KINDS OF INSURANCE — LIMITS OF RISK — REINSURANCE	288
§ 41-501. Definitions not mutually exclusive.	290
§ 41-502. “Life insurance” defined.	291
§ 41-503. “Disability insurance” defined.	292
§ 41-504. “Property insurance” defined.	293
§ 41-505. “Marine and transportation insurance” defined.	294
§ 41-506. “Casualty insurance” defined.	296
§ 41-507. “Surety insurance” defined.	300
§ 41-508. “Title insurance” defined.	301
§ 41-509. Limit of risk.	302
§ 41-510. “Reinsurance” defined.	304
§ 41-511. Authorized reinsurance.	305

§ 41-512. Reinsurance by impaired or withdrawing insurers — Penalty for violation.	307
§ 41-513. “Share and deposit insurance” defined.	309
§ 41-514. Purpose.	310
§ 41-515. Credit for reinsurance.	311
§ 41-516. Individual or group accident and sickness insurance defined.	327
Chapter 6 ASSETS AND LIABILITIES	328
§ 41-601. “Assets” defined.	330
§ 41-602. Assets as deductions from liabilities.	333
§ 41-603. Assets not allowed.	334
§ 41-604. Disallowance of “wash” transactions.	336
§ 41-605. Liabilities, in general.	338
§ 41-606. Unearned premium reserve.	340
§ 41-607. Unearned premium reserve for marine and transportation insurance.	342
§ 41-608. Reserve for disability insurance.	343
§ 41-609. Loss reserves, liability insurance and worker’s compensation.	344
§ 41-610. Increase of inadequate loss reserves.	345
§ 41-611. Reserve for losses and unearned premiums — Title insurers.	346
§ 41-611A. Mortgage guaranty insurance — Contingency reserve.	348
§ 41-612. Standard valuation law — Life insurance.	349
§ 41-613. Valuation of bonds.	384
§ 41-614. Valuation of other securities.	386
§ 41-615. Valuation of property.	388
§ 41-616. Valuation of purchase money mortgages.	389
Chapter 7 INVESTMENTS	390
§ 41-701. Investments.	393
§ 41-702. Eligible investments.	395
§ 41-703. General qualifications.	396

§ 41-704. Authorization of investments.	397
§ 41-705. Record of investments.	398
§ 41-706. Diversification of investments.	400
§ 41-707. Public obligations.	403
§ 41-708. Obligations and stock of certain federal agencies.	404
§ 41-709. Irrigation district bonds.	406
§ 41-710. International bank.	407
§ 41-711. Corporate obligations.	408
§ 41-712. Certain terms defined.	409
§ 41-713. Preferred stocks — Diversification.	410
§ 41-714. Common stocks.	411
§ 41-715. Insurance stocks.	413
§ 41-716. Investment trust securities.	415
§ 41-717. Equipment trust obligations.	416
§ 41-718. Policy loans.	417
§ 41-719. Collateral loans.	418
§ 41-720. Savings and share accounts.	419
§ 41-721. Mortgage loans and contracts.	420
§ 41-722. Mortgage loan limited by property value.	422
§ 41-723. Appraisal — Limit of amount loaned.	424
§ 41-724. “Improved real property” defined.	425
§ 41-725. “Encumbrance” defined.	426
§ 41-726. Special investments by title insurer.	427
§ 41-727. Foreign securities.	428
§ 41-728. Real estate.	431
§ 41-729. Time limit for disposal of real estate.	434
§ 41-730. Disposal of ineligible property and securities.	436
§ 41-731. Prohibited investments and investment underwriting.	437
§ 41-732. Domestic reciprocal insurer.	439
§ 41-733. Subsidiary investments.	440
§ 41-734. Separate account funds.	441

§ 41-735. Miscellaneous investments.	442
§ 41-736. Permitted investments.	443
Chapter 8 ADMINISTRATION OF DEPOSITS	444
§ 41-801. Authorized deposits of insurers.	446
§ 41-802. Purpose of deposit.	447
§ 41-803. Securities eligible for deposit.	449
§ 41-804. Custodial arrangements for deposits.	451
§ 41-805. Records — Certificate of deposit.	453
§ 41-806. Assignment of securities.	454
§ 41-807. Appraisal.	455
§ 41-808. Excess deposits.	456
§ 41-809. Rights of insurer during solvency.	457
§ 41-810. Levy upon deposit.	458
§ 41-811. Deficiency of deposit.	461
§ 41-812. Duration and release of deposit.	462
§ 41-813. Proofs for release of deposit to insurer — Director's responsibility.	464
Chapter 9 INSURANCE ADMINISTRATORS	466
§ 41-901. Definitions.	468
§ 41-902. Written agreement necessary.	474
§ 41-903. Payment to administrator.	475
§ 41-904. Maintenance of information.	476
§ 41-905. Advertising — Approval.	477
§ 41-906. Premium collection and payment of claims.	478
§ 41-907. Delivery of materials to covered individuals.	480
§ 41-908. Compensation to the administrator.	481
§ 41-909. Notice to covered individuals — Disclosure of charges and fees.	482
§ 41-910. Registration requirement.	483
§ 41-911. Home state license.	484
§ 41-912. Nonresident administrator license.	489
§ 41-913. Expiration and renewal of administrator license.	491

§ 41-914. Annual report.	492
§ 41-915. Grounds for denial, suspension or revocation of license.	494
§ 41-916. Reporting of actions.	497
§ 41-917. Provisions not limiting.	498
Chapter 10 PRODUCER LICENSING	499
§ 41-1001. Purpose and scope.	503
§ 41-1002. Terms construed.	504
§ 41-1003. Definitions.	505
§ 41-1004. License required.	508
§ 41-1005. Exceptions to licensing.	512
§ 41-1006. Application for examination.	515
§ 41-1007. Application for producer license.	516
§ 41-1008. Producer license.	518
§ 41-1009. Nonresident producer license.	520
§ 41-1010. Nonresident producers — Service of process.	522
§ 41-1011. Issuance — Refusal of license.	523
§ 41-1012. Exemption from examination.	524
§ 41-1013. Continuation — Expiration of licenses — Continuing education statement.	525
§ 41-1014. Assumed names.	528
§ 41-1015. Temporary licensing.	529
§ 41-1016. Administrative penalty — Suspension, revocation, refusal of license.	531
§ 41-1017. Commissions.	536
§ 41-1018. Appointments.	538
§ 41-1019. Notification to director of termination.	539
§ 41-1020. Reciprocity.	543
§ 41-1021. Reporting of actions.	544
§ 41-1022. Insurers must accept business through licensed producers only.	545
§ 41-1023. Countersignature of policies — Power of attorney.	546

§ 41-1024. Reporting and accounting for premiums.	547
§ 41-1025. Rules.	549
§ 41-1026. Procedure following suspension, revocation, denial — Reinstatement.	550
§ 41-1027. Return of license.	552
§ 41-1028. Inactive status.	553
§ 41-1029. Severability.	555
§ 41-1030. Producer compensation.	556
§ 41-1031—41-1035. Agents, brokers and consultants — License required as to a particular insurer — Compensation — Exceptions to license requirement — Purpose of license — License for “controlled business” prohibited — Qualifications — Agents or brokers — Qualifications — Consultants. [Repealed.]	557
§ 41-1036. Records.	558
§ 41-1037. Requirements for bail agents — Findings — Purpose.	560
§ 41-1038. Definitions.	562
§ 41-1039. License required.	564
§ 41-1039A. Notice.	566
§ 41-1040. Bond required.	567
§ 41-1041. Records.	568
§ 41-1042. Collections and charges permitted.	569
§ 41-1043. Collateral.	571
§ 41-1044. Early surrender of defendant to custody — Return of premium.	572
§ 41-1045. Responsibility for actions of others.	574
§ 41-1046—41-1059. License requirements — Exceptions — Qualifications — Application — Examination — Exemption — Contents — Continuation — Expiration — Agents — Brokers. [Repealed.]	575
§ 41-1060—41-1068. Sale of insurance by vending machines — Licensed agents and brokers — Payment and sharing commissions. [Repealed.]	577

§ 41-1069. [Reserved.]	578
§ 41-1070—41-1071. Consultant’s bond — Consultant’s place of business, records. [Repealed.]	578
§ 41-1072. Consultants — Combined licensing. [Repealed.]	579
§ 41-1073—41-1080. Consultants — Sharing commissions — Nonresident — Change of address — Administrative penalty — Suspension, revocation or refusal of license — Reinstatement. [Repealed.]	580
§ 41-1081. Requirements for sale of portable electronics insurance — Findings — Purpose.	581
§ 41-1082. Definitions.	582
§ 41-1083. Licensure of vendors.	584
§ 41-1084. Requirements for sale of portable electronics insurance.	585
§ 41-1085. Authority of vendors of portable electronics.	587
§ 41-1086. Responsibility for actions of others.	589
§ 41-1087. Suspension or revocation of license.	590
§ 41-1088. Termination of portable electronics insurance.	591
§ 41-1089. Application for license and fees.	594
§ 41-1090. Short title.	596
§ 41-1091. Definitions.	597
§ 41-1092. Requirements for limited lines travel insurance producers.	598
§ 41-1093. Registration required.	601
§ 41-1094. Type of policy.	602
§ 41-1095. Responsibility of limited lines travel insurance producers.	603
§ 41-1096. No negative option or opt out.	604
§ 41-1097. Enforcement.	605
Chapter 11 ADJUSTERS	606
§ 41-1101. Scope of chapter.	608
§ 41-1102. “Adjuster” defined.	609
§ 41-1103. License required.	611

§ 41-1104. Qualifications for adjuster's license.	612
§ 41-1105. Application for license.	614
§ 41-1106. Scope of license.	615
§ 41-1107. Emergency adjusters.	616
§ 41-1108. Other provisions applicable.	617
Chapter 12 UNAUTHORIZED INSURERS AND SURPLUS LINES	618
§ 41-1201. Representing or aiding unauthorized insurer prohibited.	621
§ 41-1202. Representing or aiding unauthorized insurer prohibited — Penalty.	623
§ 41-1203. Suits by unauthorized insurer prohibited.	624
§ 41-1204. Unauthorized insurers process act — Title — Interpretation.	625
§ 41-1205. Purpose of process act.	626
§ 41-1206. Acts constituting director as process agent.	627
§ 41-1207. How process is served — Default judgment.	628
§ 41-1208. Defense of action by unauthorized insurer.	630
§ 41-1209. Unauthorized insurer failing to pay claim — Attorney fees.	632
§ 41-1210. Exemptions from process act.	633
§ 41-1211. Surplus line law — Short title — Purpose.	634
§ 41-1212. Exemptions from surplus line law.	635
§ 41-1213. Definitions.	637
§ 41-1214. Conditions for export.	642
§ 41-1215. Broker's affidavit.	645
§ 41-1216. Open lines for export.	646
§ 41-1217. Eligible surplus lines insurers.	648
§ 41-1218. Eligible surplus line insurers — Penalty for violation.	649
§ 41-1219. Evidence of the insurance — Changes — Penalty.	650
§ 41-1220. Endorsement of contract.	652
§ 41-1221. Surplus line insurance valid.	653

§ 41-1222. Liability of insurer as to losses and unearned premiums.	654
§ 41-1223. Licensing of surplus line brokers.	655
§ 41-1224. Suspension or revocation of broker's license.	657
§ 41-1225. Broker's bond. [Repealed.]	659
§ 41-1226. Acceptance of business from agents.	660
§ 41-1227. Records of broker.	661
§ 41-1228. Annual report of broker.	662
§ 41-1229. Tax on surplus lines.	663
§ 41-1230. Failure to file report or remit tax — Penalty.	665
§ 41-1231. Legal process against surplus line insurer.	666
§ 41-1232. Rules and regulations.	667
§ 41-1233. Report and tax of independently procured coverages.	668
§ 41-1234. Records of insureds.	670
§ 41-1235. False advertising act.	671
§ 41-1236. Misrepresentation by unauthorized insurer.	672
§ 41-1237. Misrepresentation — Action and penalties.	673
Chapter 13 TRADE PRACTICES AND FRAUDS	674
§ 41-1301. Purposes of trade practices law.	677
§ 41-1302. Unfair methods of competition and deceptive act prohibited.	679
§ 41-1303. Misrepresentation or false advertising of policies.	680
§ 41-1304. False information and advertising with respect to insurance business.	682
§ 41-1305. "Twisting" prohibited.	683
§ 41-1306. False financial statements.	684
§ 41-1307. Representations as to assets or financial condition — Assessment plan to be stated in advertising.	685
§ 41-1308. Defamation.	686
§ 41-1309. Boycott, coercion and intimidation.	687
§ 41-1310. Person financing purchase of property not to favor	688

insurer or agent.	
§ 41-1311. Seller of property not to favor insurer or agent.	689
§ 41-1312. Rights with respect to insurance on property sold or purchased.	690
§ 41-1313. Unfair discrimination — Life insurance, annuities, and disability insurance.	692
§ 41-1314. Rebates — Illegal inducements.	693
§ 41-1315. Exceptions to discrimination or rebate provision — Life or disability policies, and annuity contracts.	696
§ 41-1315A. Discounts to employees.	698
§ 41-1316. Stock operations and advisory board contracts.	699
§ 41-1317. Fictitious groups.	700
§ 41-1318. Interlocking ownership or management.	702
§ 41-1319. Desist orders for prohibited practices. [Repealed.]	703
§ 41-1320. Service of notices and processes. [Repealed.]	704
§ 41-1321. Procedures as to undefined practices.	705
§ 41-1322. Appeal by intervenor. [Repealed.]	706
§ 41-1323. Illegal dealing in premiums — Excess charges for insurance.	707
§ 41-1324. Report of exact consideration to insurer.	709
§ 41-1325. Borrowing money from clients.	710
§ 41-1326. [Amended and Redesignated.]	711
§ 41-1327. Violations — Penalty.	712
§ 41-1328. Payment of claims by insurers.	713
§ 41-1328A. Repair of motor vehicles.	714
§ 41-1328B. Definitions.	715
§ 41-1328C. Identification of parts.	716
§ 41-1328D. Use of parts — Disclosure.	717
§ 41-1329. Unfair claim settlement practices.	718
§ 41-1329A. Unfair claims settlement practices — Penalty.	722
§ 41-1330. Failure to maintain complaint handling procedures.	723

§ 41-1331. Claims forms statement.	724
§ 41-1332. Return of unearned premium for disability policies.	725
§ 41-1333. Refund of unearned health insurance premiums.	726
§ 41-1334. Disclosure of nonpublic personal information.	727
§ 41-1335. Release of patient identifiable prescription information prohibited — Exceptions.	728
§ 41-1336. Requirements for compliance.	729
§ 41-1337. Life insurance — Payment of interest on benefits.	730
§ 41-1338. Uninsured vehicle tracking — Penalties.	732
Chapter 14 PROPERTY INSURANCE RATES	733
§ 41-1401. Scope of chapter.	736
§ 41-1402. Purpose of law — Interpretation.	738
§ 41-1403, 41-1404. Insurer's election where two laws apply — Rate-making factors. [Repealed.]	739
§ 41-1405. Rate standards.	740
§ 41-1406—41-1414. Rate filings required — Exemptions — Effective date — Disapproval — Excess rates — Deviations — Submission to examining bureau. [Repealed.]	742
§ 41-1415. Rating organizations — Licensing.	743
§ 41-1416. Period license effective — Renewal — Fee — Suspension or revocation.	745
§ 41-1417. Admission of subscribers — Services nondiscriminatory.	746
§ 41-1418, 41-1419. Expenses of property insurance rating organization — Rules not to affect dividends. [Repealed.]	747
§ 41-1420. Notice of rating organization changes.	748
§ 41-1421. Technical services.	749
§ 41-1422—41-1424. Appeal by minority — Information to insureds — Appeal from filing. [Repealed.]	750
§ 41-1425. Advisory organizations.	751
§ 41-1426. Joint underwriting or joint reinsurance.	752
§ 41-1427. Examination of insurers and rating, advisory, joint	753

underwriting, and joint reinsurance organizations.	
§ 41-1428. Recording and reporting of loss and expense experience.	755
§ 41-1429. Interchange of data — Consultation.	757
§ 41-1430. Disclosure of information and immunity.	758
§ 41-1431. False or misleading information.	759
§ 41-1432. Penalties for violations or noncompliance.	760
§ 41-1433. Rules and regulations.	761
§ 41-1434. Hearing procedure.	762
§ 41-1435. Appeal from the director. [Repealed.]	763
§ 41-1436. Definitions.	764
§ 41-1437. Making and use of rates.	766
§ 41-1438. Two or more insurers may act in concert.	767
§ 41-1439. Records.	769
§ 41-1440. Hearings.	771
§ 41-1441. Assigned risks.	774
Chapter 15 MANAGING GENERAL AGENTS ACT	775
§ 41-1501. Short title.	777
§ 41-1502. Definitions.	778
§ 41-1503. Licensure.	780
§ 41-1504. Required contract provisions.	781
§ 41-1505. Duties of insurers.	784
§ 41-1506. Examination authority.	786
§ 41-1507. Penalties and liabilities.	787
Chapter 16 WORKER'S COMPENSATION RATES	788
§ 41-1601. Scope of chapter.	791
§ 41-1602. Declaration of policy — Purpose.	792
§ 41-1603. Rate-making factors.	793
§ 41-1604. Rate standard.	794
§ 41-1605. Uniformity.	795
§ 41-1606. Rate filings required.	796
§ 41-1607. Exemption from filing.	797

§ 41-1608. Effective date of filing.	798
§ 41-1609. Disapproval of filing within the waiting period.	799
§ 41-1610. Subsequent disapproval of filing.	800
§ 41-1611. Scope of disapproval power.	801
§ 41-1612. Adherence to filings.	802
§ 41-1613. Excess rates.	804
§ 41-1614. Deviations.	805
§ 41-1615. Rating organization membership required.	807
§ 41-1616. Rating organization minimum membership.	808
§ 41-1617. Rating organization committees.	809
§ 41-1618. Applicability of chapter as to certain powers of state insurance manager, and to certain public employment.	810
[Repealed.]	
§ 41-1619. Other provisions applicable.	811
§ 41-1620. Rating organizations.	812
§ 41-1621. Appeal by minority.	815
§ 41-1622. Information to insureds — Review of insured's complaint.	816
§ 41-1623. Appeal from filing.	817
§ 41-1624. Cooperation among rating organizations and insurers.	818
§ 41-1625. Hearings and appeal — Scope of provisions.	819
[Repealed.]	
§ 41-1626. Compensation reimbursement option.	820
Chapter 17 BUSINESS TRANSACTED WITH BROKER CONTROLLED INSURER	822
§ 41-1701. Short title.	824
§ 41-1702. Definitions.	826
§ 41-1703. Applicability.	828
§ 41-1704. Minimum standards.	829
§ 41-1705. Disclosure.	833
§ 41-1706. Penalties.	834
Chapter 18 THE INSURANCE CONTRACT	836

§ 41-1801. Scope of chapter.	840
§ 41-1802. “Policy” defined.	841
§ 41-1803. “Premium” defined.	842
§ 41-1804. Insurable interest — Personal insurance.	843
§ 41-1805. Life insurance for benefit of certain institutions.	845
§ 41-1806. Insurable interest — Property.	846
§ 41-1807. Power to contract — Purchase of insurance by minors.	849
§ 41-1808. Application required — Life and disability insurance.	851
§ 41-1809. Alteration of application — Life and disability insurance.	852
§ 41-1810. Application as evidence.	853
§ 41-1811. Representations in applications.	854
§ 41-1812. Filing, use and disapproval of forms.	858
§ 41-1813. Grounds for disapproval.	860
§ 41-1814. Standard provisions in general.	861
§ 41-1815. Contents of policies in general.	863
§ 41-1816. Assessment policies — Special contents.	865
§ 41-1817. Additional policy contents.	866
§ 41-1818. Charter and by-law provisions.	867
§ 41-1819. Execution of policies.	868
§ 41-1820. Underwriters’ and combination policies.	869
§ 41-1821. Validity and construction of noncomplying forms.	870
§ 41-1822. Construction of policies.	871
§ 41-1823. Binders.	872
§ 41-1824. Delivery of policy.	874
§ 41-1825. Renewal by certificate.	876
§ 41-1826. Assignment of policies.	877
§ 41-1827. Right to inspect policies in force.	878
§ 41-1828. Payment discharges insurer — Payment to marital community.	879

§ 41-1829. Minor may give acquittance. [Repealed.]	880
§ 41-1830. Notice of lapse or termination of individual life insurance.	881
§ 41-1831. Forms for proof of loss to be furnished.	883
§ 41-1832. Claims administration not waiver.	884
§ 41-1833. Exemption of proceeds — Life insurance.	885
§ 41-1834. Exemption of proceeds — Disability insurance.	887
§ 41-1835. Exemption of proceeds — Group insurance.	888
§ 41-1836. Exemption of proceeds — Annuity contracts — Assignability of rights.	889
§ 41-1837. Return of unearned premiums on destruction of property.	893
§ 41-1838. Venue of suits against insurers.	894
§ 41-1839. Allowance of attorney's fees in suits against or in arbitration with insurers.	895
§ 41-1840. Prepayment of claims.	924
§ 41-1841. Block cancellations and block nonrenewals — Notice to director required.	928
§ 41-1842. Commercial insurance — Cancellation — Nonrenewal.	929
§ 41-1843. Insurance rates and credit rating.	934
§ 41-1844. Prescription drug benefit restrictions prohibited.	935
§ 41-1845. Recreational-related activities.	936
§ 41-1846. Health care policies — Applicability — Requirement.	937
§ 41-1847. Assignment of health insurance contracts.	939
§ 41-1848. Legislative findings and purpose — Coverage for abortions in state exchange prohibited.	940
§ 41-1849. Contracts with providers of dental services.	942
§ 41-1850. Certificates of insurance.	944
§ 41-1851. Electronic notices and documents.	948
§ 41-1852. Discrimination against living organ donors prohibited.	951

Chapter 19 LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS	952
§ 41-1901. Scope of chapter.	956
§ 41-1902. “Industrial life insurance” defined.	957
§ 41-1903. Standard provisions required.	958
§ 41-1904. Grace period.	959
§ 41-1905. Incontestability.	960
§ 41-1906. Entire contract.	961
§ 41-1907. Misstatement of age.	962
§ 41-1908. Dividends.	963
§ 41-1909. Policy loan.	964
§ 41-1910. Table of installments.	969
§ 41-1911. Reinstatement.	970
§ 41-1912. Payment of premiums.	972
§ 41-1913. Payment of claims.	973
§ 41-1914. Beneficiary — Industrial policies.	974
§ 41-1915. Title.	975
§ 41-1916. Excluded or restricted coverage.	976
§ 41-1917. Standard provisions — Annuity and pure endowment contracts.	977
§ 41-1918. Grace period — Annuities.	978
§ 41-1919. Incontestability — Annuities.	979
§ 41-1920. Entire contract — Annuities.	980
§ 41-1921. Misstatement of age or sex — Annuities.	981
§ 41-1922. Dividends — Annuities.	982
§ 41-1923. Reinstatement — Annuities.	983
§ 41-1924. Standard provisions — Reversionary annuities.	984
§ 41-1925. Limitation of liability.	985
§ 41-1926. Prohibited provisions — Industrial life insurance.	987
§ 41-1927. Standard nonforfeiture law — Life insurance.	988
§ 41-1927A. Standard nonforfeiture law for individual deferred annuities.	1007

§ 41-1928. Nonforfeiture benefits — Certain interim policies.	1014
§ 41-1929. Incontestability and limitation of liability after reinstatement.	1016
§ 41-1930. Policy settlements.	1017
§ 41-1931. Indebtedness deducted from proceeds.	1018
§ 41-1932. Participating and nonparticipating policies — Right to issue.	1019
§ 41-1933. Participating and nonparticipating policies — Accounting.	1020
§ 41-1934. Prohibited policy plans.	1022
§ 41-1935. Life insurance and annuities — Twenty day free examination.	1025
§ 41-1936. Separate accounts — Operation and management.	1026
§ 41-1937. Variable contracts — Statement of essential features.	1028
§ 41-1938. Variable contracts — Authority of insurer to issue.	1029
§ 41-1939. Variable contracts — Regulation thereof.	1030
§ 41-1940. Suitability of annuity sales to consumers.	1031
§ 41-1941. Annuity sales to consumers — Disclosures.	1033
§ 41-1942. Advertisement of interest-indexed annuities.	1039
§ 41-1943. Standards for policy provisions for annuities.	1040
§ 41-1944—41-1949. [Reserved.]	1041
§ 41-1950. Short title and scope.	1041
§ 41-1951. Definitions.	1042
§ 41-1952. License requirement.	1050
§ 41-1953. Filing of life settlement contracts and disclosure statements.	1051
§ 41-1954. Reporting requirements and privacy.	1052
§ 41-1955. Examination and records.	1053
§ 41-1956. Disclosure to owner upon application.	1054
§ 41-1957. Disclosure to owner by provider upon settlement contract.	1057
§ 41-1958. Disclosure to owner by broker upon settlement	1058

contract.	
§ 41-1959. Notice of change by provider.	1059
§ 41-1960. General rules.	1060
§ 41-1961. Permitted life settlements and supporting documentation.	1064
§ 41-1962. Prohibited practices and conflicts of interest.	1066
§ 41-1963. Advertising for life settlements.	1068
§ 41-1964. Penalty — Unfair trade practices.	1069
§ 41-1965. Authority to promulgate rules.	1070
Chapter 20 GROUP LIFE INSURANCE	1071
§ 41-2001. Scope of chapter — Short title.	1074
§ 41-2002. Group contracts must meet group requirements.	1075
§ 41-2003. Employee groups.	1077
§ 41-2004. Labor union groups.	1079
§ 41-2005. Debtor groups.	1080
§ 41-2006. Public employee groups.	1082
§ 41-2007. Trustee groups.	1084
§ 41-2008. Credit union groups.	1086
§ 41-2009. Dependents' coverage.	1087
§ 41-2010. Provisions required in group contracts.	1089
§ 41-2011. Grace period.	1090
§ 41-2012. Incontestability.	1091
§ 41-2013. Application — Statements deemed representations.	1093
§ 41-2014. Insurability.	1094
§ 41-2015. Misstatement of age.	1095
§ 41-2016. Payment of benefits.	1096
§ 41-2017. Certificate.	1097
§ 41-2018. Conversion on termination of eligibility.	1098
§ 41-2019. Conversion on termination of policy.	1099
§ 41-2020. Death pending conversion.	1100
§ 41-2021. Notice as to conversion right.	1101

§ 41-2022. Readjustment of premium.	1102
§ 41-2023. Application of dividends — Rate reductions.	1103
§ 41-2024. “Employee life insurance” defined.	1104
§ 41-2025. Assignment of incidents of ownership in group life insurance policies, including conversion privileges.	1105
§ 41-2026. Policy standards — Replacement contracts.	1106
Chapter 21 DISABILITY INSURANCE POLICIES	1107
§ 41-2101. Scope of chapter.	1110
§ 41-2102. Short title.	1111
§ 41-2103. Scope and format of policy.	1112
§ 41-2104. Required provisions — Captions — Omissions — Substitutions.	1115
§ 41-2105. Entire contract — Changes.	1117
§ 41-2106. Time limit on certain defenses.	1118
§ 41-2107. Grace period.	1120
§ 41-2108. Reinstatement.	1121
§ 41-2109. Notice of claim.	1122
§ 41-2110. Claim forms.	1123
§ 41-2111. Proofs of loss.	1124
§ 41-2112. Time of payment of claims.	1126
§ 41-2113. Payment of claims.	1127
§ 41-2114. Physical examination — Autopsy.	1129
§ 41-2115. Legal actions.	1130
§ 41-2116. Change of beneficiary.	1131
§ 41-2117. Optional policy provisions.	1132
§ 41-2118. Change of occupation.	1133
§ 41-2119. Misstatement of age.	1134
§ 41-2120—41-2122. Other insurance in this insurer — Insurance with other insurers — Provision of service or expense incurred basis — Other benefits. [Repealed.]	1135
§ 41-2123. Relation of earnings to insurance.	1136
§ 41-2124. Unpaid premiums.	1138

§ 41-2125. Conformity with state statutes.	1139
§ 41-2126. Illegal occupation.	1140
§ 41-2127. Intoxicants and narcotics.	1141
§ 41-2128. Renewability.	1142
§ 41-2129. Order of certain provisions.	1143
§ 41-2130. Third party ownership.	1144
§ 41-2131. Requirements of other jurisdictions.	1145
§ 41-2132. Policies issued for delivery in another state.	1146
§ 41-2133. Conforming to statute.	1147
§ 41-2134. Age limit.	1148
§ 41-2135. Prohibited policy plans — Provisions.	1149
§ 41-2136. Filing of rates.	1150
§ 41-2137. Franchise Disability Insurance Law.	1151
§ 41-2138. Health insurance — Ten-day free examination.	1152
§ 41-2139. Required provisions — Coverage of dependent child.	1153
§ 41-2140. Required provisions.	1154
§ 41-2141. Coordination of benefits — Coordination with social security benefits.	1157
§ 41-2142. Limitation of benefits for elective abortions.	1159
§ 41-2143. Services provided by governmental entities.	1160
§ 41-2144. Mammography coverage.	1161
§ 41-2145. Health insurance coverage for dependent children.	1162
[Repealed.]	
§ 41-2146. Coverage provided to persons having insurance.	1163
Chapter 22 GROUP AND BLANKET DISABILITY INSURANCE	1165
§ 41-2201. Scope of chapter — Short title.	1168
§ 41-2202. “Group disability insurance” defined — Eligible groups.	1169
§ 41-2203. Required provisions in group policies.	1171
§ 41-2204. Direct payment of hospital and medical services.	1173

§ 41-2205. Readjustment of premiums — Dividends.	1174
§ 41-2206. “Blanket disability insurance” defined.	1175
§ 41-2207. Required provisions in blanket policies.	1177
§ 41-2208. Application and certificates not required.	1179
§ 41-2209. Payment of benefits under blanket policy.	1180
§ 41-2210. Required provision in group and blanket policies.	1181
§ 41-2210A. Limitation of benefits for elective abortions.	1185
§ 41-2210D. Conversion plan — When required.	1186
§ 41-2211. Scope of act — Replacement of group disability insurance, group nonprofit hospital and medical service contracts and health care service plans.	1187
§ 41-2212. Definitions.	1188
§ 41-2213. Policy standards — Disabled individuals.	1190
§ 41-2214. Policy standards — Maternity benefits.	1192
§ 41-2215. Policy standards — Replacement contracts.	1193
§ 41-2216. Coordination of benefits — Coordination with social security benefits.	1195
§ 41-2217. Services provided by governmental entities.	1197
§ 41-2218. Mammography coverage.	1198
§ 41-2219. Health insurance coverage for dependent children. [Repealed.]	1199
§ 41-2220. Coverage provided to persons having insurance.	1200
§ 41-2221. Crediting of preexisting condition waiting period.	1203
§ 41-2222. [Reserved.]	1207
§ 41-2223. Renewability of coverage.	1207
Chapter 23 CREDIT LIFE AND CREDIT DISABILITY INSURANCE	1210
§ 41-2301. Declaration of purpose.	1212
§ 41-2302. Short title.	1213
§ 41-2303. Scope of chapter.	1214
§ 41-2304. Definitions.	1215
§ 41-2305. Forms of credit life insurance and credit disability insurance.	1216

§ 41-2306. Amount of insurance.	1217
§ 41-2307. Term of credit life insurance and credit disability insurance.	1218
§ 41-2308. Provisions of policies and certificates of insurance — Disclosure to debtors.	1220
§ 41-2309. Filing, approval and withdrawal of forms.	1222
§ 41-2310. Premiums and refunds.	1224
§ 41-2311. Issuance of policies.	1225
§ 41-2312. Claims.	1226
§ 41-2313. Existing insurance — Choice of insurer.	1227
§ 41-2314. Enforcement.	1228
§ 41-2315. Judicial review. [Repealed.]	1229
§ 41-2316. Penalties.	1230
Chapter 24 PROPERTY INSURANCE CONTRACTS	1231
§ 41-2401. Standard fire policy.	1233
Chapter 25 CASUALTY INSURANCE CONTRACTS	1240
§ 41-2501. Contracts are subject to general provisions.	1243
§ 41-2502. Uninsured motorist and underinsured motorist coverage for automobile insurance — Exceptions.	1245
§ 41-2503. Definitions and application.	1253
§ 41-2504. Application of uninsured motorist coverage.	1255
§ 41-2505. Subrogation rights of insurer.	1256
§ 41-2506. Cancellation of policies — Definitions.	1257
§ 41-2507. Cancellation of policies — Grounds.	1259
§ 41-2508. Notice of cancellation or intention not to renew.	1262
§ 41-2509. Cancellations and nonrenewal — Exceptions to.	1264
§ 41-2510. Exclusion and cancellation of designated individuals.	1265
§ 41-2511. Deductible — Permissive.	1266
§ 41-2512. Relieving liability for disclosure of cancellation and nonrenewal information.	1267
§ 41-2513. Workmen's [worker's] compensation policies —	1268

Segregation of participating and nonparticipating business.	
§ 41-2514. Medical payments limitation prohibited.	1269
§ 41-2515. Discount for certain age groups.	1270
§ 41-2516. Optional suspension of automobile insurance coverage.	1272
§ 41-2517. Short title.	1273
§ 41-2518. Definitions.	1274
§ 41-2519. Financial responsibility of transportation network companies and drivers — Proof of coverage.	1276
§ 41-2520. Disclosures.	1279
§ 41-2521. Automobile insurance.	1280
Chapter 26 SURETY INSURANCE CONTRACTS	1282
§ 41-2601, 41-2602. Director's certificate as to authorized surety insurers, withdrawing insurers. [Repealed.]	1284
§ 41-2603. Justification of surety — Director's certificate as evidence.	1285
§ 41-2604. May be sole surety on bonds.	1287
§ 41-2605. Certificate as evidence of authority to be sole surety.	1289
§ 41-2606. Premiums on bonds — Allowance as expense costs — Limit as to amount.	1290
§ 41-2607. Bond premiums as part of costs in actions and proceedings.	1291
§ 41-2608. Deposit for protection of surety.	1292
§ 41-2609. Release of surety on certain official bonds.	1293
§ 41-2610. Estoppel to deny corporate power.	1295
§ 41-2611. Deduction of bond premium from wages of employees.	1296
§ 41-2612. Release of surety on bond of licensee or permittee.	1297
§ 41-2613. Surety companies authorized to become surety under arrest bond certificate — Certificate as cash bail.	1298
Chapter 26A MORTGAGE GUARANTY INSURANCE	1300
§ 41-2650. Short title.	1302

§ 41-2651. Definitions.	1303
§ 41-2652. Authority to transact business.	1305
§ 41-2653. Limits of risk.	1306
§ 41-2654. Reserves.	1308
§ 41-2655. Schedule of premium charges.	1309
§ 41-2656. Advertising.	1310
Chapter 27 TITLE INSURANCE	1311
§ 41-2701. Scope of chapter.	1313
§ 41-2702. Countersignature of policies.	1314
§ 41-2703. Other provisions especially applicable.	1315
§ 41-2704. Application of act — Business of title insurance.	1317
§ 41-2705. Supervision — Policy forms — Premiums.	1318
§ 41-2706. Title insurance rates — Justification.	1321
§ 41-2707. Filing of title insurance rates — Hearings.	1324
§ 41-2708. Determination of insurability — Prohibited risks — Rebates.	1327
§ 41-2709. Personal or controlled insurance.	1330
§ 41-2710. Requirements for agents.	1332
§ 41-2711. Requirements for title insurance related business — Bonds.	1336
§ 41-2712. Title insurance rating organization.	1339
§ 41-2713. Administration — Examination costs.	1342
§ 41-2714. Closing or settlement protection.	1344
Chapter 28 ORGANIZATION AND CORPORATE PROCEDURES OF STOCK AND MUTUAL INSURERS	1346
§ 41-2801. Scope of chapter.	1350
§ 41-2802. “Stock” insurer — “Mutual” insurer — Definitions.	1351
§ 41-2803. Applicability of general corporation statutes.	1352
§ 41-2804. Incorporation.	1353
§ 41-2805. Filing of articles.	1355
§ 41-2806—41-2808. Permit required to offer securities or to	1357

solicit qualifying applications for insurance — Penalty — Application for penalty — Application for permit to solicit qualifying mutual applications. [Repealed.]	
§ 41-2809. Investigation of proposed organization.	1358
§ 41-2810—41-2817. Granting or denial of permit — Terms of permit — Compliance — Permit as inducement — Modification or revocation of permit — Bond for permit — Escrow of funds — Subscriptions — Failure to complete or qualify. [Repealed.]	1359
§ 41-2818. Qualification for initial certificate of authority — Stock insurers.	1360
§ 41-2819. Subsequent financing. [Repealed.]	1361
§ 41-2820. Initial qualifications — Domestic mutuals.	1362
§ 41-2821. Formation of mutual insurer — Bond. [Repealed.]	1363
§ 41-2822. Applications for insurance in formation of mutual insurer.	1364
§ 41-2823. Formation of mutuals — Trust deposit of premiums — Issuance of policies.	1366
§ 41-2824. Formation of mutuals — Failure to qualify.	1367
§ 41-2825. Additional kinds of insurance — Mutuals.	1368
§ 41-2826. Amendment of articles of incorporation — Stock insurers.	1369
§ 41-2827. Amendment of articles of incorporation — Mutual insurer.	1370
§ 41-2828. Insurance business exclusive.	1372
§ 41-2829. Membership in mutuals.	1373
§ 41-2830. By-laws of mutual.	1374
§ 41-2831. Rights of mutual members in general.	1375
§ 41-2832. Meetings of members of mutual insurer.	1376
§ 41-2833. Special meetings of members of mutual insurer.	1378
§ 41-2834. Voting rights of mutual members.	1379
§ 41-2835. Directors.	1380
§ 41-2836. Notice of change of directors or officers.	1382

§ 41-2837. Prohibited pecuniary interest of officials.	1383
§ 41-2838. Management and exclusive agency contracts.	1385
§ 41-2839. Home office — Records — Assets — Penalty for unlawful removal.	1387
§ 41-2840. Vouchers for expenditures.	1390
§ 41-2841. Borrowed surplus.	1391
§ 41-2842. Participating policies.	1393
§ 41-2843. Dividends to stockholders.	1394
§ 41-2844. Dividends to policy holders.	1396
§ 41-2845. Illegal dividends — Penalty.	1397
§ 41-2846. Contingent liability of mutual members.	1398
§ 41-2847. Levy of contingent liability.	1400
§ 41-2848. Enforcement of contingent liability.	1402
§ 41-2849. Nonassessable policies — Mutual insurers.	1403
§ 41-2850. Nonassessable policies — Revocation of authority.	1404
§ 41-2851. Solicitations in other states.	1405
§ 41-2852. Impairment of capital or assets.	1406
§ 41-2853. Assessment of stockholders or members.	1408
§ 41-2854. Mutualization of stock insurers.	1410
§ 41-2854A. Mutualization of service corporations.	1412
§ 41-2855. Conversion of mutual insurer to stock insurer.	1418
§ 41-2856. Mergers and consolidations of stock insurers.	1421
§ 41-2857. Mergers and consolidations of mutual insurers.	1423
§ 41-2858. Bulk reinsurance — Mutual insurers.	1425
§ 41-2859. Mutual member's share of assets on liquidation.	1427
§ 41-2860. Equity securities of domestic stock insurance companies — Statements of ownership.	1428
§ 41-2861. Recovery of profits resulting from unfair use of information.	1429
§ 41-2862. Restrictions on sale of equity securities.	1430
§ 41-2863. Purchases and sales which are exempt.	1431

§ 41-2864. Foreign or domestic arbitrage transactions exempt.	1432
§ 41-2865. “Equity security” defined.	1433
§ 41-2866. Conditions exempting equity securities.	1434
§ 41-2867. Rules and regulations.	1435
§ 41-2868. Proxy regulations.	1436
§ 41-2869. Purpose.	1439
§ 41-2870. Definitions.	1440
§ 41-2871. Use of book-entry systems.	1441
§ 41-2872. Health care provider contracts — Grievance procedure.	1442
§ 41-2873. Best price — Most favored nations clause prohibited.	1444
Chapter 29 RECIPROCAL INSURERS	1445
§ 41-2901. “Reciprocal” insurance defined.	1448
§ 41-2902. “Reciprocal insurer” defined.	1449
§ 41-2903. Scope of chapter — Existing insurers.	1450
§ 41-2904. Insuring powers of reciprocals.	1452
§ 41-2905. Name — Suits.	1453
§ 41-2906. Surplus funds required.	1454
§ 41-2907. Attorney.	1455
§ 41-2908. Organization of reciprocal insurer.	1456
§ 41-2909. Certificate of authority.	1458
§ 41-2910. Power of attorney or joint powers entity.	1459
§ 41-2911. Modifications.	1461
§ 41-2912. Attorney’s bond.	1462
§ 41-2913. Deposit in lieu of bond.	1463
§ 41-2914. Action on bond.	1464
§ 41-2915. Service of process — Judgment.	1465
§ 41-2916. Contributions to insurer.	1466
§ 41-2917. Annual statement.	1467
§ 41-2918. Financial condition — Method of determining.	1468
§ 41-2919. Who may be subscribers.	1469

§ 41-2920. Subscribers' advisory committee.	1470
§ 41-2921. Subscribers' liability.	1471
§ 41-2922. Subscribers' liability on judgment.	1472
§ 41-2923. Assessments.	1473
§ 41-2924. Time limit for assessment.	1474
§ 41-2925. Aggregate liability.	1475
§ 41-2926. Nonassessable policies.	1476
§ 41-2927. Distribution of savings.	1478
§ 41-2928. Subscribers' share in assets.	1479
§ 41-2929. Merger or conversion.	1480
§ 41-2930. Impaired reciprocals.	1481
Chapter 30 IDAHO UNCLAIMED LIFE INSURANCE BENEFITS ACT	1482
§ 41-3001. Definitions.	1484
§ 41-3002. Insurer conduct.	1486
§ 41-3003. Unfair trade practices.	1489
Chapter 31 COUNTY MUTUAL INSURERS	1490
§ 41-3101. Scope of chapter — Provisions exclusive.	1492
§ 41-3102. Organization of county mutual fire insurers.	1493
§ 41-3102A. Conversion into domestic mutual.	1495
§ 41-3103. Filing of articles — Commencement of business.	1497
§ 41-3104. Insuring powers.	1498
§ 41-3104A. Property used to fight fires — Charges.	1500
§ 41-3105. Insurer's territory.	1501
§ 41-3106. Limit of risk.	1502
§ 41-3107. Reinsurance.	1503
§ 41-3108. Certificate of authority required.	1504
§ 41-3109. Directors.	1506
§ 41-3110. Members.	1507
§ 41-3111. Advance payments by members.	1509
§ 41-3112. Assessments.	1510
§ 41-3112A. Advance premiums — Return premiums.	1511

§ 41-3113. Expenses.	1512
§ 41-3114. Investments.	1513
§ 41-3115. Site for head office.	1514
§ 41-3116. Records — Annual statement.	1515
§ 41-3117. Amendment of articles of incorporation.	1516
§ 41-3118. Fees.	1517
§ 41-3119. Other provisions applicable.	1518
Chapter 32 FRATERNAL BENEFIT SOCIETIES	1521
§ 41-3201. Fraternal benefit societies.	1524
§ 41-3202. Lodge system.	1526
§ 41-3203. Representative form of government.	1527
§ 41-3204. Terms used.	1529
§ 41-3205. Purposes and powers.	1531
§ 41-3206. Qualifications for membership.	1532
§ 41-3207. Location of office, meetings, communications to members, grievance procedures.	1533
§ 41-3208. No personal liability.	1534
§ 41-3209. Waiver.	1536
§ 41-3210. Organization.	1537
§ 41-3211. Amendments to laws.	1541
§ 41-3212. Institutions.	1543
§ 41-3213. Reinsurance.	1544
§ 41-3214. Consolidations and mergers.	1545
§ 41-3215. Conversion of fraternal benefit society into a mutual life insurance company.	1547
§ 41-3216. Benefits.	1548
§ 41-3217. Beneficiaries.	1550
§ 41-3218. Benefits not attachable.	1551
§ 41-3219. The benefit contract.	1552
§ 41-3220. Nonforfeiture benefits, cash surrender values, certificate loans and other options.	1555
§ 41-3221. Investments.	1556

§ 41-3222. Funds.	1557
§ 41-3223. Taxation.	1558
§ 41-3224. Valuation.	1559
§ 41-3225. Reports.	1561
§ 41-3226. License.	1563
§ 41-3227. Examination of societies — No adverse publications.	1565
§ 41-3228. Foreign or alien society — Admission.	1566
§ 41-3229. Injunction — Liquidation — Receivership of domestic society.	1567
§ 41-3230. Suspension, revocation or refusal of license of foreign or alien society.	1569
§ 41-3231. Injunction.	1571
§ 41-3232. Licensing of agents.	1572
§ 41-3233. Unfair methods of competition and unfair and deceptive acts and practices.	1573
§ 41-3234. Service of process.	1574
§ 41-3235. Fees.	1575
§ 41-3236. Penalties.	1576
§ 41-3237. Exemption of certain societies.	1577
§ 41-3238. Review.	1579
§ 41-3239. Other provisions applicable.	1580
§ 41-3240—41-3245. Taxation — Exemptions — Penalties — Fraternal benefit society fees — Applicability of other provisions. [Repealed.]	1583
Chapter 33 INSURERS SUPERVISION, REHABILITATION AND LIQUIDATION	1584
§ 41-3301. Construction and purpose.	1588
§ 41-3302. Persons covered.	1590
§ 41-3303. Definitions.	1591
§ 41-3304. Jurisdiction and venue.	1595
§ 41-3305. Injunctions and orders.	1597
§ 41-3306. Cooperations of officers, owners, and employees.	1599

§ 41-3307. Bonds.	1601
§ 41-3308. Continuation of delinquency proceedings.	1602
§ 41-3309. Director's summary orders and supervision proceedings.	1603
§ 41-3310. Court's seizure order.	1606
§ 41-3311. Hearings.	1608
§ 41-3312. Grounds for rehabilitation.	1609
§ 41-3313. Rehabilitation orders.	1612
§ 41-3314. Powers and duties of the rehabilitator.	1613
§ 41-3315. Actions by and against rehabilitator.	1615
§ 41-3316. Termination of rehabilitation.	1616
§ 41-3317. Grounds for liquidation.	1617
§ 41-3318. Liquidation orders.	1618
§ 41-3319. Continuance of coverage.	1620
§ 41-3320. Insurer — Dissolution.	1621
§ 41-3321. Powers of liquidator.	1622
§ 41-3322. Notice to creditors and others.	1626
§ 41-3323. Duties of agents.	1628
§ 41-3324. Actions by and against liquidator.	1630
§ 41-3325. Collection and list of assets.	1632
§ 41-3326. Fraudulent transfers prior to petition.	1633
§ 41-3327. Fraudulent transfer after petition.	1635
§ 41-3328. Voidable preferences and liens.	1637
§ 41-3329. Claims of holders of void or voidable rights.	1642
§ 41-3330. Setoffs.	1643
§ 41-3331. Assessments.	1644
§ 41-3332. Reinsurer's liability.	1646
§ 41-3333. Recovery of premiums owed.	1647
§ 41-3334. Domiciliary liquidator's proposal to distribute assets.	1648
§ 41-3335. Filing of claims.	1650
§ 41-3336. Proof of claim.	1652

§ 41-3337. Special claims.	1654
§ 41-3338. Special provisions for third party claims.	1655
§ 41-3339. Disputed claims.	1657
§ 41-3340. Claims of surety.	1658
§ 41-3341. Secured creditor's claims.	1659
§ 41-3342. Priority of distribution.	1660
§ 41-3343. Liquidator's recommendations to the court.	1663
§ 41-3344. Distribution of assets.	1664
§ 41-3345. Unclaimed and withheld funds.	1665
§ 41-3346. Termination of proceedings.	1666
§ 41-3347. Reopening liquidation.	1667
§ 41-3348. Disposition of records during and after termination of liquidation.	1668
§ 41-3349. External audit of the receiver's books.	1669
§ 41-3350. Conservation of property of foreign or alien insurers found in this state.	1670
§ 41-3351. Liquidation of property of foreign or alien insurers found in this state.	1672
§ 41-3352. Domiciliary liquidators in other states.	1674
§ 41-3353. Ancillary formal proceedings.	1675
§ 41-3354. Ancillary summary proceedings.	1676
§ 41-3355. Claims of nonresidents against insurers domiciled in this state.	1677
§ 41-3356. Claims of residents against insurers domiciled in reciprocal states.	1678
§ 41-3357. Attachment, garnishment, and levy of execution.	1679
§ 41-3358. Interstate priorities.	1680
§ 41-3359. Subordination of claims for noncooperation.	1681
§ 41-3360. Severability.	1682
Chapter 34 HOSPITAL AND PROFESSIONAL SERVICE CORPORATIONS	1683
§ 41-3401. Scope of chapter.	1687
§ 41-3402. Purpose and interpretation.	1689

§ 41-3403. Definitions.	1690
§ 41-3404. Provisions exclusive.	1692
§ 41-3404A, 41-3404B. Application to dental service corporation. [Repealed.]	1693
§ 41-3405. Incorporation — Certificate of authority required.	1694
§ 41-3406. Incorporation — Laws applicable — Approval of articles of incorporation — Amendment.	1695
§ 41-3407. Name of corporation.	1698
§ 41-3408. Qualifications for certificate of authority.	1699
§ 41-3409. Application for certificate of authority.	1702
§ 41-3410. Issuance or refusal of certificate of authority.	1704
§ 41-3411. Continuance or expiration of certificate of authority.	1705
§ 41-3412. Suspension or revocation of certificate of authority.	1706
§ 41-3413. Services and benefits which may be provided professional service corporations.	1707
§ 41-3414. Services and benefits which may be provided — Hospital service corporations.	1709
§ 41-3414A. Services provided by pharmaceutical service corporation. [Repealed.]	1710
§ 41-3415. Professional service agreements.	1711
§ 41-3415A. Pharmacists' service agreements.	1713
§ 41-3416. Hospital service agreements.	1715
§ 41-3417. Subscriber's contracts.	1717
§ 41-3418. Service agreements and subscriber's contracts must provide substantial service benefits.	1720
§ 41-3419. Filing and approval of agreements and contracts.	1722
§ 41-3420. Charges and rates.	1724
§ 41-3421. Reserves.	1725
§ 41-3422. Surplus fund.	1727
§ 41-3423. Investments.	1728
§ 41-3424. Records and accounts.	1729

§ 41-3425. Annual statement.	1730
§ 41-3426. Examination.	1731
§ 41-3427. Taxation and annual report.	1733
§ 41-3428. Joint operations.	1735
§ 41-3429. Combined corporation.	1736
§ 41-3430. Contracts covering workmen's [worker's] compensation risks.	1737
§ 41-3431. Annual adjustment of service payments — Disposition of excess funds.	1739
§ 41-3432. Fidelity bond.	1740
§ 41-3433. Service corporation fees.	1741
§ 41-3434. Other provisions applicable.	1742
§ 41-3435. Producer licensing.	1747
§ 41-3436. Dependent's coverage — Dependent's termination of coverage, disability and dependency proof and application.	1748
§ 41-3437. Required provisions — Infants.	1750
§ 41-3438. Complications of pregnancy.	1752
§ 41-3439. Limitation of benefits for elective abortions.	1754
§ 41-3440. Services provided by governmental entities.	1755
§ 41-3441. Mammography coverage.	1756
§ 41-3442. Health insurance coverage for dependent children. [Repealed.]	1757
§ 41-3443. Best price — Most favored nations clause prohibited.	1758
§ 41-3444. Contracts with providers of dental services.	1759
Chapter 35 INSURANCE OF PUBLIC PROPERTY AND RISKS	1761
§ 41-3501. Division of purchasing to procure insurance. [Repealed.]	1763
§ 41-3502. Procurement of official bonds.	1764
§ 41-3503. Payment of premiums.	1765
§ 41-3504—41-3506. Liability insurance policies — Special endorsement — Limited waiver of defense of sovereign immunity. [Repealed.]	1766

Chapter 36 INSURANCE GUARANTY ASSOCIATION	1767
§ 41-3601. Short title.	1770
§ 41-3602. Purpose of act. [Repealed.]	1771
§ 41-3603. Application of act.	1772
§ 41-3604. Liberal construction of act. [Repealed.]	1774
§ 41-3605. Definitions.	1775
§ 41-3606. Insurance guaranty association — Insurers required to be members — Purposes.	1779
§ 41-3607. Board of directors — Number — Election or appointment — Reimbursement for expenses.	1780
§ 41-3608. Obligations and powers of association.	1781
§ 41-3609. Plan of operation — Approval — Adoption of interim rules by director — Contents of plan — Delegation of powers and duties — Reimbursement of delegate corporation or organization.	1786
§ 41-3610. Duties and powers of director — Judicial review.	1789
§ 41-3611. Subrogation of association to rights of claimants — Receiver, liquidator, or successor bound by association claim settlements — Periodic filing of statements of paid claims with receiver or liquidator.	1791
§ 41-3612. Exhaustion of other coverage.	1793
§ 41-3613. Prevention of insolvencies.	1794
§ 41-3614. Regulation by director — Annual reports to director.	1796
§ 41-3615. Exemption from taxes — Exception.	1797
§ 41-3616. Credits for assessments paid.	1798
§ 41-3617. No liability for actions taken pursuant to act.	1800
§ 41-3618. Stay of court proceedings for insolvency — Setting aside judgment against insolvent insurer.	1801
§ 41-3619. Protection of act not used to sell insurance.	1802
§ 41-3620. Termination of operation of association as to insurance covered by other plan — Dissolution of association and distribution of assets — Expiration of act.	1803

§ 41-3621. Cooperation of liquidator, receiver, or statutory successor of an insolvent insurer.	1805
Chapter 37 IDAHO HOSPITAL LIABILITY TRUST ACT	1806
§ 41-3701. Declaration of purpose. [Repealed.]	1808
§ 41-3702. Definitions. [Repealed.]	1809
§ 41-3703. Trust agreements among a group of hospitals authorized. [Repealed.]	1810
§ 41-3704. Title to property of trusts — Liability of trusts and trustees. [Repealed.]	1811
§ 41-3705. Obligation of participating hospitals limited. [Repealed.]	1812
§ 41-3706. Registration. [Repealed.]	1813
§ 41-3707. Qualifications for registration. [Repealed.]	1814
§ 41-3708. Application for registration — Fee. [Repealed.]	1815
§ 41-3709. Grant or denial of registration. [Repealed.]	1816
§ 41-3710. Trust fund — Powers. [Repealed.]	1817
§ 41-3711. Trust fund — Liability. [Repealed.]	1818
§ 41-3712. Investment of trust fund. [Repealed.]	1819
§ 41-3713. Reserves. [Repealed.]	1820
§ 41-3714. Records and accounts — Annual statement. [Repealed.]	1821
§ 41-3715. Taxes. [Repealed.]	1822
§ 41-3716. Examination of books, records and accounts. [Repealed.]	1823
§ 41-3717. Trustees — Administrators — Bonding. [Repealed.]	1824
§ 41-3718. Prohibited pecuniary interests in plan management. [Repealed.]	1825
§ 41-3719. Political contributions prohibited. [Repealed.]	1826
§ 41-3720. Recovery of depleted funds. [Repealed.]	1827
§ 41-3721. Termination of registration. [Repealed.]	1828
§ 41-3722. Liquidation of trust fund. [Repealed.]	1829
§ 41-3723. Other provisions applicable. [Repealed.]	1830

§ 41-3724. Penalties. [Repealed.]	1831
§ 41-3725. Rules and regulations. [Repealed.]	1832
§ 41-3726. Application of chapter. [Repealed.]	1833
§ 41-3727. Insurance. [Repealed.]	1834
§ 41-3728. Certificate of membership. [Repealed.]	1835
§ 41-3729. Severability. [Repealed.]	1836
Chapter 38 ACQUISITIONS OF CONTROL AND INSURANCE HOLDING COMPANY SYSTEMS	1837
§ 41-3801. Purpose.	1840
§ 41-3802. Definitions.	1843
§ 41-3803. Subsidiaries of insurers.	1846
§ 41-3804. Acquisition of control of controlling interest with domestic insurer — Acquisition of merger or divestiture of controlling interest with domestic insurer.	1849
§ 41-3805. Tender offer material.	1855
§ 41-3806. Approval by director — Hearings.	1856
§ 41-3807. Mailing — Payment of expenses.	1860
§ 41-3808. Acquisitions involving insurers not otherwise covered.	1861
§ 41-3809. Registration of holding company system insurers.	1868
§ 41-3810. Standards and management of an insurer within an insurance holding company system.	1874
§ 41-3811. Adequacy of surplus.	1878
§ 41-3812. Dividends and other distributions.	1879
§ 41-3813. Management of domestic insurers subject to registration.	1882
§ 41-3814. Examination.	1884
§ 41-3815. Supervisory colleges.	1886
§ 41-3815A. Group-wide supervision of internationally active insurance groups.	1888
§ 41-3816. Confidential treatment.	1893
§ 41-3817. Rules.	1897
§ 41-3818. Injunctions, prohibitions against voting securities,	1898

sequestration of voting securities.	
§ 41-3819. Sanctions.	1900
§ 41-3820. Receivership.	1902
§ 41-3821. Recovery.	1903
§ 41-3822. Revocation, suspension or nonrenewal of insurer's license.	1905
§ 41-3823. Judicial review — Mandamus.	1906
§ 41-3824. Mutual insurance holding companies.	1907
§ 41-3825. Severability.	1913
Chapter 39 MANAGED CARE REFORM	1914
§ 41-3901. Short title.	1917
§ 41-3902. Intent and purpose.	1918
§ 41-3903. Definitions.	1919
§ 41-3904. Certificate of authority required — Exceptions — Application of certain provisions.	1923
§ 41-3905. Qualifications for certificate of authority.	1925
§ 41-3906. Application for certificate of authority.	1929
§ 41-3907, 41-3908. Issuance, refusal of certificate of authority — Expiration, continuation of certificate of authority. [Repealed.]	1932
§ 41-3909. Records.	1933
§ 41-3910. Reports to the director.	1934
§ 41-3911. Examinations.	1935
§ 41-3912. Suspension or revocation of certificate of authority.	1936
§ 41-3913. Powers of health maintenance organizations. [Repealed.]	1937
§ 41-3914. Annual disclosures.	1938
§ 41-3915. Health care contracts.	1940
§ 41-3916. Advisory panels.	1944
§ 41-3917. Certain words prohibited in name of organization.	1945
§ 41-3918. Grievance system.	1946
§ 41-3919. Open enrollment.	1948

§ 41-3920. Discrimination against health professionals associated with managed care organizations.	1950
§ 41-3921. Statutory construction and relationship to other laws.	1951
§ 41-3922. Taxation — Penalty for failure to file.	1953
§ 41-3923. Coverage of adopted newborn children — Coverage of maternity and complications of pregnancy.	1954
§ 41-3924. Limitation of benefits for elective abortions.	1958
§ 41-3925. Services provided by governmental entities.	1959
§ 41-3926. Mammography coverage.	1961
§ 41-3927. Health care providers — Participation by any qualified, willing provider — Contracts — Grievance procedure.	1963
§ 41-3928. Incentives to withhold care prohibited.	1966
§ 41-3929. Health insurance coverage for dependent children. [Repealed.]	1967
§ 41-3930. Utilization management program requirements.	1968
§ 41-3931. Participation in Idaho life and health insurance guaranty association.	1970
§ 41-3932. Exemptions from application of chapter.	1971
§ 41-3933. Subordinated indebtedness. [Repealed.]	1973
§ 41-3934. [Amended and Redesignated.]	1974
§ 41-3935. [Amended and Redesignated.]	1975
§ 41-3936. [Amended and Redesignated.]	1976
§ 41-3937. [Amended and Redesignated.]	1977
§ 41-3938. [Amended and Redesignated.]	1978
§ 41-3940. Preexisting conditions.	1979
Chapter 40 SELF-FUNDED HEALTH CARE PLANS	1980
§ 41-4001. Declaration of purpose.	1983
§ 41-4002. Definitions.	1985
§ 41-4003. Registration required — Exemptions — Not subject to insurance code.	1989
§ 41-4004. Plan requirements.	1992

§ 41-4005. Application for registration — Fee.	1995
§ 41-4006. Grant or denial of registration.	1999
§ 41-4007. Trust fund — Authority.	2001
§ 41-4008. Trust fund liability — Fiduciary funds.	2002
§ 41-4009. Investment of trust fund.	2003
§ 41-4010. Reserves and surplus.	2005
§ 41-4011. Records and accounts — Annual statement.	2008
§ 41-4012. Taxes.	2011
§ 41-4013. Examination of books, records and accounts.	2013
§ 41-4014. Trustees — Administrators — Bonding.	2015
§ 41-4015. Prohibited pecuniary interests in plan management.	2017
§ 41-4016. Political contributions prohibited.	2019
§ 41-4017. Recovery of depleted funds.	2020
§ 41-4018. Termination of registration.	2021
§ 41-4019. Liquidation of trust fund.	2023
§ 41-4020. Rules.	2025
§ 41-4021. Other provisions applicable.	2026
§ 41-4022. Penalties.	2027
§ 41-4023. Coverage from moment of birth — Complications of pregnancy.	2030
§ 41-4024. Services provided by governmental entities.	2034
§ 41-4025. Mammography coverage.	2035
§ 41-4026. Health insurance coverage for dependent children.	2036
[Repealed.]	

Chapter 41 JOINT PUBLIC AGENCY SELF-FUNDED HEALTH CARE PLANS 2037

§ 41-4101. Declaration of purpose.	2040
§ 41-4102. Definitions.	2041
§ 41-4103. Registration required — Exemptions — Not subject to insurance code.	2043
§ 41-4104. Qualifications for registration.	2044

§ 41-4105. Application for registration.	2046
§ 41-4106. Grant or denial of application.	2048
§ 41-4107. Trust fund — Powers.	2049
§ 41-4108. Trust fund liability.	2050
§ 41-4109. Investment of trust fund.	2051
§ 41-4110. Reserves.	2053
§ 41-4111. Records and accounts — Annual statement.	2055
§ 41-4112. Taxes — Exemption.	2057
§ 41-4113. Examination of books, records and accounts.	2058
§ 41-4114. Board of trustees — Administrators.	2059
§ 41-4115. Prohibited pecuniary interests in plan management.	2060
§ 41-4116. Political contributions prohibited.	2061
§ 41-4117. Recovery of depleted funds.	2062
§ 41-4118. Termination of registration.	2063
§ 41-4119. Liquidation of trust fund.	2064
§ 41-4120. Rules.	2065
§ 41-4121. Other provisions applicable.	2066
§ 41-4122. Penalties.	2067
§ 41-4123. Coverage from moment of birth — Complications of pregnancy.	2068
§ 41-4124. Services provided by governmental entities.	2071
§ 41-4125. Mammography coverage.	2073
Chapter 42 INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES	2074
§ 41-4201. Purpose.	2076
§ 41-4202. Definitions.	2077
§ 41-4203. Standards for policy provisions.	2078
§ 41-4204. Minimum standards for benefits.	2080
§ 41-4205. Outline of coverage.	2082
§ 41-4206. Pre-existing conditions. [Repealed.]	2084
§ 41-4207. Administrative procedure.	2085

Chapter 43 IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT	2086
§ 41-4301. Short title.	2088
§ 41-4302. Purpose.	2090
§ 41-4303. Coverage and limitations.	2091
§ 41-4304. Construction.	2098
§ 41-4305. Definitions.	2099
§ 41-4306. Creation of the association.	2105
§ 41-4307. Board of directors.	2106
§ 41-4308. Powers and duties of the association.	2107
§ 41-4309. Assessments.	2116
§ 41-4310. Plan of operation.	2121
§ 41-4311. Duties and powers of the director.	2123
§ 41-4312. Prevention of insolvencies.	2125
§ 41-4313. Credits for assessments paid.	2127
§ 41-4314. Miscellaneous provisions.	2129
§ 41-4315. Examination of the association — Annual report.	2132
§ 41-4316. Tax exemptions.	2133
§ 41-4317. Immunity.	2134
§ 41-4318. Stay of proceedings — Reopening default judgments.	2135
§ 41-4319. Prohibited advertisement of insurance guaranty association act in commercial sales.	2136
§ 41-4320. Application.	2137
Chapter 44 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS	2138
§ 41-4401. Purpose.	2140
§ 41-4402. Definitions.	2142
§ 41-4403. Applicability and scope.	2144
§ 41-4404. Standards for policy provisions and authority to promulgate rules.	2145
§ 41-4405. Loss ratio standards.	2147

§ 41-4406. Disclosure standards.	2148
§ 41-4407. Notice of free examination.	2150
§ 41-4408. Filing requirements for advertising.	2151
§ 41-4409. Administrative procedures.	2152
§ 41-4410. Penalties.	2153
§ 41-4411. Separability.	2154
Chapter 45 MOTOR CLUBS	2155
§ 41-4501 — 41-4529. [Repealed.]	2157
Chapter 46 LONG-TERM CARE INSURANCE ACT	2158
§ 41-4601. Purpose.	2160
§ 41-4602. Scope.	2162
§ 41-4603. Definitions.	2163
§ 41-4604. Extraterritorial jurisdiction — Group long-term care insurance.	2166
§ 41-4605. Disclosure and performance standards for long-term care insurance.	2167
§ 41-4606. Incontestability period.	2173
§ 41-4607. Nonforfeiture benefits.	2175
§ 41-4608. Authority to promulgate rules.	2177
§ 41-4609. Administrative procedures.	2178
§ 41-4610. Severability.	2179
§ 41-4611. Penalties.	2180
Chapter 47 SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT	2181
§ 41-4701. Short title.	2183
§ 41-4702. Purpose.	2184
§ 41-4703. Definitions.	2185
§ 41-4704. Applicability and scope.	2192
§ 41-4705. Establishment of classes of business.	2194
§ 41-4706. Restrictions relating to premium rates.	2196
§ 41-4707. Renewability of coverage.	2201
§ 41-4708. Availability of coverage — Preexisting conditions	2204

— Portability.	
§ 41-4708A. [Reserved.]	2208
§ 41-4708B. Conversion plan — When required.	2208
§ 41-4709. Notice of intent to operate as a risk-assuming carrier or a reinsuring carrier.	2209
§ 41-4710. Application to become a risk-assuming carrier.	2210
§ 41-4711. Small employer carrier [health] reinsurance program.	2212
§ 41-4712. Small employer health benefit plans.	2220
§ 41-4713. Periodic market evaluation.	2222
§ 41-4714. Waiver of certain state laws. [Repealed.]	2223
§ 41-4715. Administrative procedures.	2224
§ 41-4716. Standards to assure fair marketing.	2225
§ 41-4717. Health insurance coverage for dependent children. [Repealed.]	2228
§ 41-4718. Catastrophic plans. [Repealed.]	2229
Chapter 48 RISK RETENTION GROUPS	2230
§ 41-4801. Short title.	2232
§ 41-4802. Purpose.	2233
§ 41-4803. Definitions.	2234
§ 41-4804. Risk retention groups chartered in this state.	2239
§ 41-4805. Risk retention groups not chartered in this state.	2241
§ 41-4806. Compulsory associations.	2245
§ 41-4807. Counter signatures not required.	2246
§ 41-4808. Purchasing groups — Exemption from certain laws relating to the group purchase of insurance.	2247
§ 41-4809. Notice and registration requirements of purchasing groups.	2248
§ 41-4810. Restrictions on insurance purchased by purchasing groups.	2250
§ 41-4811. Administrative and procedural authority regarding risk retention groups and purchasing groups.	2251
§ 41-4812. Penalties.	2252

§ 41-4813. Duty of agents or brokers to obtain license.	2253
§ 41-4814. Binding effect of orders issued in U.S. district courts.	2254
§ 41-4815. Rules and regulations.	2255
§ 41-4816. Purchasing group taxation.	2256
Chapter 49 PETROLEUM CLEAN WATER TRUST FUND ACT	2257
§ 41-4901. Short title.	2261
§ 41-4902. Legislative findings and intent.	2262
§ 41-4903. Definitions.	2264
§ 41-4904. Board of trustees of the fund.	2270
§ 41-4905. Creation, authorization and management of the Idaho petroleum clean water trust fund.	2273
§ 41-4906. Limits of liability for contracts of insurance issued by the administrator.	2277
§ 41-4907. Owner or operator financial responsibility.	2279
§ 41-4908. Exclusiveness of remedy.	2280
§ 41-4909. Source of trust fund — Application fees — Application for enrollment — Transfer fees.	2281
§ 41-4910. Distribution of application fees and transfer fees.	2287
§ 41-4910A. Apportionment of moneys transferred to the state highway account from the Idaho petroleum clean water trust fund suspense account on April 1, 1997.	2291
§ 41-4911. Issuance of contracts of insurance by the administrator of the Idaho petroleum clean water trust fund — Deferral.	2293
§ 41-4911A. Provisions of contracts of insurance — Renewal.	2295
§ 41-4912. Storage tanks eligible for insurance.	2296
§ 41-4912A. Storage tanks located on sites where contamination is present.	2298
§ 41-4913. State treasurer custodian of trust fund — Duties.	2300
§ 41-4914. Deposit and investment of funds — Interest.	2301
§ 41-4915. Perpetual appropriation.	2302
§ 41-4916. Enrolled subscribers' liability on judgment.	2303

§ 41-4917. Actions for collection in case of default — Penalty — Cancellation of insurance contract.	2304
§ 41-4918. Cancellation of insurance.	2305
§ 41-4919. Reinsurance.	2306
§ 41-4920. Payments from the trust fund by state treasurer.	2307
§ 41-4921. Reserve funds.	2308
§ 41-4922. Plan of operation.	2309
§ 41-4923. Registration of the trust fund.	2310
§ 41-4924. Qualifications for registration.	2311
§ 41-4925. Application for registration — Fee.	2312
§ 41-4925A. Amendments to plan of operation.	2313
§ 41-4926. Grant or denial of registration.	2314
§ 41-4927. Bylaws of the fund.	2315
§ 41-4928. Records and accounts — Annual statement.	2316
§ 41-4929. Management contract with the administrator — Mandatory provisions.	2317
§ 41-4930. Existing insurance laws to apply to the trust fund with certain exceptions.	2319
§ 41-4931. Taxes.	2321
§ 41-4932. Examination of books, records and accounts.	2322
§ 41-4933. Administrator — Fidelity bonds.	2323
§ 41-4934. Prohibited pecuniary interests in plan management.	2324
§ 41-4935. Political contributions prohibited.	2326
§ 41-4936. Recovery of depleted funds.	2327
§ 41-4937. Impaired trust fund.	2328
§ 41-4938. Liquidation of trust fund.	2330
§ 41-4939. Vouchers for expenditures.	2332
§ 41-4940. Borrowed surplus and subordinated indebtedness.	2333
§ 41-4941. Penalties.	2335
§ 41-4942. Rules — Director — Department of insurance.	2337
§ 41-4943. Application of chapter.	2338

§ 41-4944. Insurance.	2339
§ 41-4945. Personal liability.	2340
§ 41-4946. Actions against the fund, the board, its employees, and administrator subject to the Idaho tort claims act.	2341
§ 41-4948. Legislative review of program. [Repealed.]	2342
Chapter 50 UNDERGROUND STORAGE TANK UPGRADE ASSISTANCE PROGRAM	2343
§ 41-5001 — 41-5006. Underground storage tank upgrade assistance program. [Repealed.]	2345
Chapter 51 REINSURANCE INTERMEDIARY ACT	2346
§ 41-5101. Short title.	2348
§ 41-5102. Definitions.	2349
§ 41-5103. Licensure.	2352
§ 41-5104. Required contract provisions — Reinsurance intermediary — Brokers.	2355
§ 41-5105. Books and records — Reinsurance intermediary brokers.	2356
§ 41-5106. Duties of insurers utilizing the services of a reinsurance intermediary — Broker.	2357
§ 41-5107. Required contract provisions — Reinsurance intermediary — Managers.	2358
§ 41-5108. Prohibited acts.	2362
§ 41-5109. Duties of reinsurers utilizing the services of a reinsurance intermediary — Manager.	2363
§ 41-5110. Examination authority.	2365
§ 41-5111. Penalties and liabilities.	2366
Chapter 52 INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT	2367
§ 41-5201. Short title.	2369
§ 41-5202. Purpose.	2370
§ 41-5203. Definitions.	2371
§ 41-5204. Applicability and scope.	2377
§ 41-5205. [Reserved.]	2379

§ 41-5206. Restrictions relating to premium rates.	2379
§ 41-5207. Renewability of coverage.	2384
§ 41-5208. Availability of coverage — Preexisting conditions — Portability.	2387
§ 41-5209. Notice of intent to operate as a risk-assuming carrier or a reinsuring carrier.	2391
§ 41-5210. Application to become a risk-assuming carrier.	2392
§ 41-5211. Administrative procedures.	2394
§ 41-5212. Standards to assure fair marketing.	2395
§ 41-5213. Catastrophic plans. [Repealed.]	2398
§ 41-5214. Enhanced short-term plans.	2399
Chapter 53 MEDICAL CARE SAVINGS ACCOUNT ACT	2400
§ 41-5301 — 41-5306. Medical Care Savings Account Act. [Repealed.]	2402
Chapter 54 RISK-BASED CAPITAL (RBC) FOR INSURERS ACT	2403
§ 41-5401. Definitions.	2405
§ 41-5402. RBC Reports.	2408
§ 41-5403. Company action level event.	2410
§ 41-5404. Regulatory action level event.	2414
§ 41-5405. Authorized control level event.	2417
§ 41-5406. Mandatory control level event.	2419
§ 41-5407. Hearings.	2421
§ 41-5408. Confidentiality — Prohibition on announcements, prohibition on use in ratemaking.	2422
§ 41-5409. Supplemental provisions — Rules — Exemption.	2425
§ 41-5410. Foreign insurers.	2427
§ 41-5411. Immunity.	2429
§ 41-5412. Notices.	2430
§ 41-5413. Severability.	2431
Chapter 55 IDAHO INDIVIDUAL HIGH RISK REINSURANCE POOL	2432
§ 41-5501. Definitions.	2434

§ 41-5502. Creation of the individual high risk reinsurance pool — Board.	2438
§ 41-5503. Plan of operation.	2440
§ 41-5504. Powers and authority.	2442
§ 41-5505. Reinsurance.	2444
§ 41-5506. Reinsurance premium rates.	2446
§ 41-5507. Premium rates for high risk pool plan coverage.	2447
§ 41-5508. Assessments.	2449
§ 41-5509. Ceding eligibility.	2451
§ 41-5510. [Amended and Redesignated.]	2453
§ 41-5511. Design of products. [Repealed.]	2454
Chapter 56 PROMPT PAYMENT OF CLAIMS	2455
§ 41-5601. Definitions.	2457
§ 41-5602. Prompt payment of claims.	2459
§ 41-5603. Interest payments.	2461
§ 41-5604. Assignment.	2462
§ 41-5605. Exceptions.	2463
§ 41-5606. Penalties.	2465
Chapter 57 INTERSTATE INSURANCE PRODUCT REGULATION COMPACT	2466
§ 41-5701. Preamble.	2468
§ 41-5702. Interstate Insurance Product Regulation Compact.	2469
Chapter 58 PUBLIC ADJUSTER LICENSING ACT	2493
§ 41-5801. Purpose and scope.	2495
§ 41-5802. Definitions.	2496
§ 41-5803. License required.	2498
§ 41-5804. Exceptions to licensing.	2499
§ 41-5805. Application for license. [Effective upon a state's participation in NAIC's central repository — See note below.]	2500
§ 41-5806. License qualifications.	2502
§ 41-5807. Examination.	2504
§ 41-5808. Exemptions from examination.	2505

§ 41-5809. Nonresident license reciprocity.	2507
§ 41-5810. License.	2509
§ 41-5811. License denial, nonrenewal or revocation.	2511
§ 41-5812. Bond or letter of credit.	2514
§ 41-5813. Continuing education.	2516
§ 41-5814. Public adjuster fees.	2518
§ 41-5815. Contract between public adjuster and insured.	2519
§ 41-5816. Escrow or trust accounts.	2523
§ 41-5817. Record retention.	2524
§ 41-5818. Standards of conduct of public adjuster.	2526
§ 41-5819. Reporting of actions.	2528
§ 41-5820. Rules.	2529
§ 41-5821. Severability.	2530
Chapter 59 IDAHO HEALTH CARRIER EXTERNAL REVIEW ACT	2531
§ 41-5901. Short title.	2533
§ 41-5902. Purpose and intent.	2534
§ 41-5903. Definitions.	2535
§ 41-5904. Applicability and scope.	2544
§ 41-5905. Notice of right to external review.	2546
§ 41-5906. Request for external review.	2548
§ 41-5907. Exhaustion of internal grievance process.	2549
§ 41-5908. Standard external review.	2551
§ 41-5909. Expedited external review.	2557
§ 41-5910. Binding nature of external review decision.	2562
§ 41-5911. Approval of independent review organizations.	2563
§ 41-5912. Minimum qualifications for independent review organizations.	2566
§ 41-5913. Hold harmless for independent review organizations.	2570
§ 41-5914. External review reporting requirements.	2571
§ 41-5915. Funding of external review.	2573

§ 41-5916. Disclosure requirements.	2574
§ 41-5917. Severability.	2576
Chapter 60 IMMUNIZATION ASSESSMENTS	2577
§ 41-6001. Legislative intent. [Null and void, effective July 1, 2024.]	2579
§ 41-6002. Definitions. [Null and void, effective July 1, 2024.]	2580
§ 41-6003. Idaho immunization assessment board. [Null and void, effective July 1, 2024.]	2583
§ 41-6004. Plan of operation. [Null and void, effective July 1, 2024.]	2586
§ 41-6005. Power and liability of the board. [Null and void, effective July 1, 2024.]	2587
§ 41-6006. Assessments. [Null and void, effective July 1, 2024.]	2589
§ 41-6007. Idaho immunization dedicated vaccine fund. [Null and void, effective July 1, 2024.]	2592
§ 41-6008. Rulemaking authority. [Null and void, effective July 1, 2024.]	2594
Chapter 61 IDAHO HEALTH INSURANCE EXCHANGE ACT	2595
§ 41-6101. Short title.	2597
§ 41-6102. Purpose and intent.	2598
§ 41-6103. Definitions.	2599
§ 41-6104. Establishment of the exchange and the board.	2601
§ 41-6105. Powers and authority of the exchange.	2605
§ 41-6106. Report.	2609
§ 41-6107. Relation to other laws.	2611
§ 41-6108. Idaho contractors in a health insurance exchange.	2612
§ 41-6109. Severability.	2613
Chapter 62 IDAHO MOTOR VEHICLE SERVICE CONTRACT ACT	2614
§ 41-6201. Short title.	2616
§ 41-6202. Legislative intent.	2617

§ 41-6203. Definitions.	2618
§ 41-6204. Service contract reimbursement policy requirements.	2621
§ 41-6205. Motor vehicle service contract provisions.	2623
§ 41-6206. Motor vehicle service contract requirements.	2625
§ 41-6207. Prohibited acts.	2626
§ 41-6208. Recordkeeping requirements.	2628
§ 41-6209. Licensing.	2629
§ 41-6210. Guaranty.	2630
§ 41-6211. Enforcement and penalties.	2631
Chapter 63 OWN RISK AND SOLVENCY ASSESSMENT	2633
§ 41-6301. Purpose and scope.	2635
§ 41-6302. Definitions.	2636
§ 41-6303. Risk management framework.	2638
§ 41-6304. ORSA requirement.	2639
§ 41-6305. ORSA summary report.	2640
§ 41-6306. Exemption.	2642
§ 41-6307. Contents of ORSA summary report.	2645
§ 41-6308. Confidentiality.	2646
Chapter 64 CORPORATE GOVERNANCE ANNUAL DISCLOSURE	2650
§ 41-6401. Purpose and scope.	2652
§ 41-6402. Definitions.	2654
§ 41-6403. Disclosure requirement.	2655
§ 41-6404. Contents of corporate governance annual disclosure.	2657
§ 41-6405. Confidentiality.	2659
§ 41-6406. NAIC and third-party consultants.	2662
Chapter 65 COVERAGE FOR PARTICIPANTS IN CLINICAL TRIALS	2664
§ 41-6501. “Routine patient care costs” defined.	2666
§ 41-6502. Required coverage.	2667

§ 41-6503. Research institutions.	2669
§ 41-6504. Limitations on coverage.	2670
§ 41-6505. Insurer liability.	2671
§ 41-6506. Deductible, coinsurance, and copayment requirements.	2672
§ 41-6507. Cancellation or nonrenewal prohibited.	2673